

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83d

06132

## CERTIFICATE OF DEATH

Reg. Dist. No.

214

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Linden, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Virginia Albron

## 3. (b) Social Security Number

4. Sex Female 5. Color or race A.A. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) May 12, 1869 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 78 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
 (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

12. Name unknown

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Broosie Brown  
 Address Linden, Md.

17. Burial Date thereof Aug. 1, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lincoln Memorial

Location Washington, D.C.

18. Funeral director Robert E. Snodden

Address 246 N. Wash. St. Rockville

19. Dec 30 1947 Josephine Schaeff  
 (Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Linden, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

2D. DATE OF DEATH July 28<sup>th</sup> 1947, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 25 1947 to July 28 1947  
 and that I last saw him alive on July 27 1947

Immediate cause of death

Hemiplegia

Due to

Arteriovascular

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter Sewell M.D.  
Norbeck Md. Date signed 7-31-47

DURATION

2 wksunknown



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 936

06133

## CERTIFICATE OF DEATH

Reg. Dist. No. 514

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Kensington  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7/9/47  
 Hospital, institution, or street address where death occurred:  
10 KNOWLES AVE  
 How long in hospital or institution? ✓

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... MONTGOMERY  
 City or town... KENSINGTON  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 10 KNOWLES AVE  
 (If rural, give LOCATION)  
 2(a) If veteran, name war... No

## 3. (a) FULL NAME

James Hopkins Adams

## 3. (b) Social Security Number

NONE4. Sex m 5. Color or race wh 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Margaret Daryl Adams7. Birth date of deceased (mo., day, yr.) DEC-9-14 18688. AGE: Years 78 Months 7 Days 4 It less than one day hrs. min.9. Birthplace S. C. (RICHMOND CO.)  
(Town, county, and state)10. Usual occupation RETIRED GOVERNMENT EMPLOYEE

11. Industry or business

12. Name WARREN ADAMS13. Birthplace S. C.14. Maiden name NATHALIE HERYWARD15. Birthplace S. C.16. Informant CHASE R ADAMSAddress 10 KNOWLES AVE KENSINGTON17. CREMATION. Date thereat 7-15-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CEDAR HILLLocation SUITLAND PR GEORGES CO. MD18. Funeral director William E. HumphreyAddress SILVER SPRING MD19. July 14 19 47 Josephine in Schreff  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7/13/47 19 47, at 5:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 46 19 46 to July 13 19 47 and that I last saw him alive on 7/13/47 19 47Immediate cause of death congestive Heart Failure DURATION 1 yearDue to arteriosclerosis  
generalized severe

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of PM

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Adams MD M. D. or otherAddress Kensington, Md Date signed 7/13/47

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JUL 18 1947  
BUREAU OF R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06134

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Somerseth  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MontgomeryCity or town Somerseth  
(If outside city or town limits, write RURAL and give nearest town)Street No. 19 Dorseth  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MARTHA LOUIS ANDERSON

## 3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Lawrence A. Anderson

7. Birth date of

deceased (mo., day, yr.)

June 26, 1862

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

85

hrs. min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Mason T. Lawrence

13. Birthplace

Va.

MOTHER

14. Maiden name

Martha Utterback

15. Birthplace

Va.

16. Informant

Kathryn C. Barnes

Address

19 Dorseth

17.

(Burial, cremation, or removal, Which?)

Date thereof

Aug. 2, 1947  
(month) (day) (year)

Cemetery or crematory

Glenwood

Location

Washington

18. Funeral director

Deed Funeral Home

Address

4812 Ga Ave NW

19.

(Date rec'd by registrar)

7/31 1947John E. Jones  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 31 19 47 at 12:07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 2819 47, toJuly 3119 47and that I last saw h. ER alive onJuly 2819 47

Immediate cause of death

HYPERTENSIVE CARDIO-  
VASCULAR DISEASE

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. W. C. St. Lawrence M.D.

M. D. or other

Address

4825 Chevy Chase Dr  
 Chevy Chase 15 M.D.Date signed 31 July 1947

RECEIVED  
AUG 6 1947  
BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

## CERTIFICATE OF DEATH

06135

Reg. Dist. No. 223

### 1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanitarium  
3 1/2 hrs.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6716 Conway Ave.  
(If rural, give LOCATION)

2.(d) If veteran, name war

### 3. (a) FULL NAME

Mrs. Charlotte Backus

### 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Gordon T. Backus Jr.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1915

8. AGE:

Years

Months

Days

If less than one day

31

7

22

hrs.

min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

12. Name DR. FRANK W. TILLEY

13. Birthplace

MAINE

14. Maiden name

BERTHA ROBLIN

15. Birthplace

WATERTOWN, N.Y.

16. Informant

Mr. Gordon Backus Jr.

Address

6716 Conway Ave Takoma Park, Md

17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof

July 11, 1947

Cemetery or crematory

Cedar Hill Cemetery

Location

Ching Ave S.E. Extended

18. Funeral director

Arthur G. Galt

Address

254 Carroll St. N.W. Takoma Park, D.C.

19. 7/10/47

(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH

July 9, 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Med Examiner's Case

and that I last saw him alive on 19

Immediate cause of death suicide

Toxic poisoning - 3rd degree

Due to body burns

Due to gas explosion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 7/9/47

Where did injury occur 6716 Conway Ave, Takoma Park, Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury gas explosion Injured at work? no

SIGNATURE E. G. Bauerfeld Jr.

Address 254 Carroll St. N.W. Takoma Park, D.C.

Date signed 7/9/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUL 11 1947

BUREAU V. M.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466X

## CERTIFICATE OF DEATH

06136

Reg. Dist. No. 216

1. PLACE OF DEATH: **Montgomery**  
 County.....  
 City or town..... **Bethesda (rural)**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
**U. S. NAVAL HOSPITAL, Bethesda, Md.**  
 How long in hospital or institution? **2 months**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... **Penn.** County.....  
 City or town..... **Germantown**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **221 West Duvall Street**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... **WWI**

3. (a) FULL NAME  
**BARNES, Fred Harold**

3. (b) Social Security Number

4. Sex **male**  
 5. Color or race **Col-US**  
 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife  
 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) **October 8, 1870**

8. AGE: Years **76** Months **7** Days **29** If less than one day  
 hrs. min.

9. Birthplace..... **Virginia**  
 (Town, county, and state)

10. Usual occupation..... **dentist assistant**

11. Industry or business

12. Name **Van BARNES dec.**

13. Birthplace **Va.**

14. Maiden name **Sarah GREGORY dec.**

15. Birthplace **Va.**

16. Informant **sister: Mrs. Lina Reed,**

Address **221 West Duvall St., Germantown, Pa.**

17. **burial** Date thereof..... **17-11-47**  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... **Arlington National**

Location **Arlington, Va.**

18. Funeral director **W. Ernest Jarvis**

Address **1432 U St., N.W., Wash., D.C.**

19. **7-7** 19 **47**  
 (Date rec'd by registrar) Registrar **Mary Charlotte Smith**

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... **7 July** 19 **47** at **11:45 AM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**May 7** 19 **47** to **July 7** 19 **47**

and that I last saw him on **7 July** 19 **47**

Immediate cause of death **adenocarcinoma of the stomach with widespread metastasis**

Due to **massive pulmonary embolism**

Due to **thrombosis of descending aorta**

Other conditions **right common iliac artery, right iliac arteriovenous aneurysm, liver.**

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... **as above**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury **falling** Injured at work?

23. SIGNATURE..... **P. R. ENGLE, Cdr. MC USN**

M. D. or other

Address **USNH Bethesda, Md.** Date signed **7-7-47**

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUL 21 1947

BUREAU 7 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

06137

50X

1. PLACE OF DEATH:  
 County Montgomery  
 City or town Silver Spring Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Md. County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1415 Forest Glen Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Leafy Beall

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife William Russell Beall  
 6.(c) If alive, give age 57 years  
 7. Birth date of deceased (mo., day, yr.) Aug. 29 - 1889  
 8. AGE: Years 57 Months 9 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Connellsville, Pa  
 (Town, county, and state)  
 10. Usual occupation Housewife

11. Industry or business  
 12. Name Charles Edmonds  
 13. Birthplace Middletown, Md.  
 14. Maiden name Rebekah Knight  
 15. Birthplace Westernport, Md

16. Informant William Russell Beall  
 Address 1415 Forest Glen Road  
 17. Burial Date thereof July 5 - 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cedar Hill  
 Location

18. Funeral director Harry L. Strye  
 Address 1009 N. St. M. St.

19. July 2 1947 Josephine M. Schaeffe  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1947 at 6:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1/47 1947 to July 2/47 1947  
 and that I last saw him alive on July 2/47 1947

Immediate cause of death Carcinoma of Breast - Metastases  
 Due to 1- DURATION 3 yrs.

Due to  
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Breast  
 Date of op. 1945 June

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Sam Allen MD  
 Address Bearsington, Md M. D. or other 1/2/47  
 Date signed

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JUL 5 1947

BUREAU F.B.I.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163

## CERTIFICATE OF DEATH

06138

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery

City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

N. Burdette

7. Birth date of deceased (mo., day, yr.)

June 24, 1903

6. (c) If alive, give age years

8. AGE:

Years 44

Months 0

Days 19

If less than one day

hrs. 19

min.

9. Birthplace

Atlanta, Ga.

City N. J.

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

FATHER

12. Name

W. Stiles

13. Birthplace

Mass.

MOTHER

14. Maiden name

Emily Tolson

15. Birthplace

Mass.

16. Informant

N. Burdette Bertrand

Address

Same

17. Burial

(Burial, cremation, or removal. Which?)

Burial

Cemetery or crematory

Greenwood Cem.

Location

In the town of Bethesda

18. Funeral director

The S. V. Kline Co.

Address

2901 14th St. N.W.

19. Date rec'd by registrar

7/13/47

Registrar

Wm E. Jones

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Wash. D.C.

County

City or town

3000 - Conn. Ave.

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH

July 13, 1947

at

5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def med. Exam case

and that I last saw him alive on

Immediate cause of death

Barbiturate poisoning

Due to

suicide

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

suicide

Where did injury occur?

Wash. D.C.

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Brochant M.D.

Address

Washington, D.C.

Date signed

7-22-47

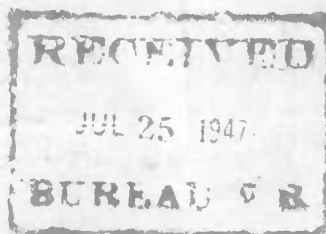
Regist. No.

216

VS A15 9/45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1330

## CERTIFICATE OF DEATH

Reg. Dist. No. 061396

## 1. PLACE OF DEATH:

County Montgomery CoCity or town Cherry Chase Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town \_\_\_\_\_  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles Fairman Boggs

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Lillian W. BoggsHow Nov. 6, 1858 8. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 89 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Ill  
(Town, county, and state)10. Usual occupation Retired

## 11. Industry or business

12. Name Samuel W. Boggs13. Birthplace Ill14. Maiden name Hannah Campbell15. Birthplace Ill16. Informant Daniel W. BoggsAddress 219-Elm St Ch Ch. Md17. Cremation Date thereof July 19, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium Edgar HillLocation Switland Md.18. Funeral director Cherry Chase Funeral HomeAddress 5103 Wisconsin Ave NW19. 7/19 47 M E Jones  
(Date rec'd by registrar) (year) (month) (day) (Name of Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 19 47 at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-15- 19 47 to 7-19- 19 47and that I last saw him alive on 7-17-47 19 \_\_\_\_\_

Immediate cause of death

1) Uremia secondary to chronic partial urethral obstruction caused by benign prostatic hypertrophy and obstruction.

Due to \_\_\_\_\_

Other conditions Pyelitis & CystitisSubacute Combined Cord degeneration 17 yrs

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Stewart Claff M.D. M. D. or otherAddress 3921 Ingomar St Wash DC Date signed 7-19-47

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JUL 25 1947

BLK 66

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 468  
CERTIFICATE OF DEATH

06140

Reg. Dist. No. 227

## 1. PLACE OF DEATH:

County Montgomery  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Residence for street address where death occurred:

212 Buffalo Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 212 Buffalo Ave  
(If rural, give LOCATION)2.(a) If veteran, name war none

## 3. (a) FULL NAME

HENRI C. BROCKDORFF

## 3. (b) Social Security Number

577-28-2882

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

malewhitemarried6. (b) Name of husband or wife Esther H.

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Feb. 26th. 18828. AGE: Years Months Days If less than one day  
65 4 26 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Copenhagen, Denmark  
(Town, county, and state)10. Usual occupation Brickwork Contractor

## 11. Industry or business

FATHER 12. Name Henri Brockdorff13. Birthplace DenmarkMOTHER 14. Maiden name Martha Sonderup15. Birthplace Denmark16. Informant Mrs. Esther H. BrockdorffAddress 212 Buffalo Ave. Takoma Park.17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/24/1947  
(month) (day) (year)Cemetery Rock CreekLocation Washington, D. C.18. Funeral director Warner E. HumphreyAddress Silver Spring, Md.19. July 20 19 47  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947 at 8:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 1946 to July 22 1947and that I last saw him alive on July 21 1947Immediate cause of death Carcinoma of

DURATION

pancreas 1 yrmultiple metastasesthroughout abdomen

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma ofpancreas Date of op. Nov 27 1946Autopsy results inoperable

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE George L. Balf MD2835 Eastern Ave M.D. or other \_\_\_\_\_Address Spring, Md Date signed July 22 1947

7805 Eastern  
New Ball.

RECEIVED

JUL 25 1947

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06339

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month, 19 days

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.How long in hospital or institution? 1 mo. 19 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. CountyCity or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1331 Columbia Road, Northwest  
(If rural, give LOCATION)2(a) If veteran, name war WW I ✓

## 3. (a) FULL NAME

BRUNSON, Thomas Roswell

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Mrs. Maudie Brunson7. Birth date of deceased (mo., day, yr.) 17 April 1881 6. (c) If alive, give age years8. AGE: Years 66 Months 2 Days 19 If less than one day hrs. min.9. Birthplace Texas  
(Town, county, and state)10. Usual occupation Civil Engineer  
Interstate Commerce Commission

11. Industry or business

12. Name Daniel Thomas Brunson13. Birthplace Georgia/ dec.14. Maiden name Fannie Chieves15. Birthplace Georgia/ dec.16. Informant Wife: Mrs. Maudie BrunsonAddress 1331 Columbia Rd., NW, Wash., D.C.17. Burial Date thereof 7-11-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Virginia18. Funeral director S.H. Hines Co.Address 2901 14th St., NW, Wash., D.C.19. 7-6- 47 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6 July 19 47 at 7:10 Am21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-17 19 47 to 7-6-47 19 47and that I last saw him alive on 7-6- 19 47Immediate cause of death SUBACUTEBACTERIAL ENDOCARDITISwith terminal bronchopneumoniaDue to Cerebral hemorrhageand uremia dueDue to to atherosclerosis, moderateOther conditions Chronic Rheumaticpanendocarditis, multiple septic infarcts

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results (Same as above)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

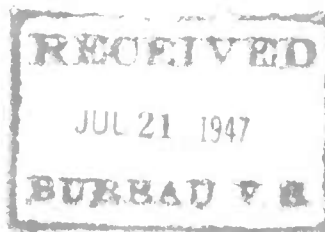
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE J.B. BRYAN LTJG MC USNRUSNH, Bethesda, Md. Date signed 7-6-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

06141

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Browningville, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 48 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Browningville, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles F. Burdette

## 3. (b) Social Security Number

\_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Roberta E. Burdette  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Nov. 1898  
 8. AGE: Years 48 Months 8 Days 15 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Montgomery Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Farm

11. Industry or business Farm  
 12. Name Willie H. Burdette  
 13. Birthplace Montgomery Co. Md.  
 14. Maiden name Mamie Fugh  
 15. Birthplace Montgomery Co. Md.  
 16. Informant Mrs. Roberta E. Burdette  
 Address Browningville, Md.  
 17. Burial Date thereof July 20, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Bethesda Md.  
 Location Browningville, Md.  
 18. Funeral director Ray W. Barber  
 Address Cottonsville, Md.  
 19. July 20, 47 Willie H. Burdette  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1947 at 10:00 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam. 19\_\_\_\_ to 19\_\_\_\_  
 and that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_  
 Immediate cause of death \_\_\_\_\_

Fractures of skull  
 Fracture of cervical  
 Ducts Veterans (accidental)  
 Due to fall from load of hay  
 Other conditions \_\_\_\_\_

## DURATION

Healed instantly

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of 7-17-47  
 Where did injury occur? Browningville, Md.  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) Farm  
 Means of injury fall Injured at work? yes

23. SIGNATURE Frank J. Brochart M.D.  
Dep. Med. Exam. M. D. or other  
 Address Yarlington, Md. Date signed 7-17-47

RECEIVED  
JUL 23 1947  
STREAN 13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

06142

## CERTIFICATE OF DEATH

Reg. Diat. No. 218

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Boyers - rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 18 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Boyers - rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Edgar D. Burns

## 3. (b) Social Security Number

217-038897

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Ella M. Burns

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July 12 1898

8. AGE: Years 48 Months 11 Days 24 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business Milk

12. Name Darwin W. Burns

13. Birthplace Maryland

14. Maiden name Campbell Haines

15. Birthplace Maryland

16. Informant Mrs. Ella M. Burns

Address Clarksburg, Maryland

17. Burial (Burial, cremation, or removal. Which?) Burial Date interred July 8 1947  
 (month) (day) (year)

Cemetery or crematorium Salem Cellar Building

Location Montgomery Co. Md

18. Funeral director Prof. W. Barker

Address Gettysville Md

19. Date rec'd by registrar July 7 1947 Registrar Abraham L. Cooke

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1947 at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Defunct Exam case to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

Gun shot wound inf 1st temple 22 cal inf

Due to \_\_\_\_\_

suicide

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 7-6-47

Where did injury occur? Boyer Montg md  
 (City or town) (County) (State)

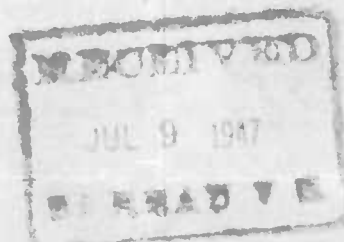
Injured at home, farm, industry, public place (where?) home

Means of injury gun shot Injured at work? no

23. SIGNATURE Frank J. Bronhart M.D.

Defunct Exam M. D. or other

Address Gettysburg Md Date signed 7-6-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06143

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Potomac  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
RFD, Rockville, Maryland  
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Potomac  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. RFD, Rockville  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war No

## 3. (a) FULL NAME

Roger Burroughs  
 4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

## 3. (b) Social Security Number

218-24-6392

6. (b) Name of husband or wife Lillie M. Burroughs  
 6. (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) July 29, 1897  
 8. AGE: Years 50 Months 0 Days 1 If less than one day hrs. min.

9. Birthplace Montgomery County, Maryland  
 (Town, county, and state)

10. Usual occupation Crane Operator

11. Industry or business Crane Operator

12. Name Lewis Burroughs

13. Birthplace Maryland

14. Maiden name Unknown Musgrove

15. Birthplace Maryland

16. Informant Lillie M. Burroughs  
 Address RFD, Rockville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 2, 1947  
 (month) (day) (year)

Cemetery or crematory Potomac Methodist Cemetery

Location Potomac, Maryland

18. Funeral director W.M. Ransom Rumphrey

Address Bethesda, Maryland

19. 8/2/47 19. 21 Thompson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 30<sup>th</sup> 19. 47 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 40 to July 30 19. 47

and that I last saw him alive on July 29<sup>th</sup> 19. 47

Immediate cause of death Chronic alcoholism DURATION

Due to

Due to

Other conditions Chronic myocarditis  
& nephritis  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.E. Newha M. D. or other

Address Rockville, Md Date signed 7/31/47

RECEIVED  
AUG 5 1947  
BUREAU V.R.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4704

## CERTIFICATE OF DEATH

06144

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 81 days  
Hospital, institution, or street address where death occurred:  
U. S. Naval Hospital, Bethesda, Maryland  
How long in hospital or institution? 81 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Arlington  
City or town Arlington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5713 8th Road, North  
(If rural, give LOCATION)  
2. (a) If veteran, name war WWI

### 3. (a) FULL NAME

CALDWELL, William Harold

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs. Florence B. Caldwell

7. Birth date of deceased (mo., day, yr.) 10 November 1886 6. (c) If alive, give age years

8. AGE: Years 60 Months 8 Days 8 If less than one day hrs. min.

9. Birthplace New York  
(Town, county, and state)

10. Usual occupation unknown

11. Industry or business unknown

12. Name Thomas B. Caldwell

13. Birthplace New York, dec.

14. Maiden name Fannie B. Flacda

15. Birthplace New York, dec.

16. Informant Wife: Mrs. Florence B. Caldwell

Address 5713 8th Rd. N., Arlington, Virginia

17. Burial Date thereof 7 22 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Virginia

18. Funeral director W. W. Chambers Co. R.J.K.

Address 3072 M Street, NW, Washington, D. C.

19. 7-18 47  
(Date rec'd by registrar) Registrar May Charlotte Smith

### MEDICAL CERTIFICATION

20. DATE OF DEATH 18 July 19 47 at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-28 19 47, to 7-18 19 47.

and that I last saw him alive on 7-18 19 47.

Immediate cause of death Post-operative death.

Due to Malignant bronchial adenoma, Right.

Due to Unknown

Other conditions

(Include pregnancy within 6 months of death)

Major findings of operations Therectomy

Tumor in R.L. Date of op. 17 July 47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

for J.D. Landhoff LTJG MC USNR

23. SIGNATURE W.B. FORD, LT MC USN

M. D. or other USNH, Bethesda, Md.

Address USNH, Bethesda, Md. Date signed 7-14-47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

7/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

## CERTIFICATE OF DEATH

06145

Reg. Diat. No. 213

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Darnestown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Germantown R.F.D.  
 How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Darnestown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Germantown R.F.D.  
 (If rural, give LOCATION)  
None  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

VIRGIE CATHERINE CASE

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife None  
 7. Birth date of deceased (mo., day, yr.) May 2nd, 1887 6.(c) If alive, give age..... years  
 8. AGE: Years Months Days If less than one day  
60 60 2 6 ..... hrs. .... min.

9. Birthplace Darnestown, Maryland  
 (Town, county, and state)  
 10. Usual occupation None  
 11. Industry or business None  
 12. Name James Joseph Case  
 13. Birthplace Montgomery County, Maryland  
 14. Maiden name Catherine Case  
 15. Birthplace Montgomery County, Maryland

16. Informant Miss Elberta Case  
 Address Darnestown, Maryland  
 17. Burial Date thereof July 10, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Darnestown Church Cemetery  
 Location Darnestown, Maryland  
 18. Funeral director Wm Reuben Humphrey  
 Address Rockville, Maryland  
 19. 7/8 19 47  
 (Date rec'd by registrar) E. S. Thompson  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 8th, 1947 5:30A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March - 14 - 1947 to July - 8 - 1947  
 and that I last saw him alive on March - 7 - 1947

Immediate cause of death  
Pulmonary Tuberculosis

## DURATION

4 mos

Due to.....  
 Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?.....  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?  
 23. SIGNATURE William C. Miller, M.D.  
 M. D. or other  
 Address Gaithersburg, Maryland Date signed 7/8/47

RECEIVED

JUL 11 1947

BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87c

## CERTIFICATE OF DEATH

 61520  
 06146  
 Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 months  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? 4 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State DC County DC  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 227-18 St S.E.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war None

## 3. (a) FULL NAME

George Henry Copes

## 3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Mamie E. Copes  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Sept 27 1865  
 8. AGE: Years 81 Months \_\_\_\_\_ Days \_\_\_\_\_ It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Retired  
 11. Industry or business \_\_\_\_\_  
 12. Name Unknown  
 13. Birthplace Unknown  
 14. Maiden name Unknown  
 15. Birthplace Unknown

16. Informant Mrs William E. Frazier  
 Address 227-8 St S.E. Wash. DC  
 17. Burial Date thereof 7-14-1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Congressional Cemetery  
 Location Washington D.C.  
 18. Funeral director J. William Lee's Sons Co  
 Address 300-4 St N.E. Wash. D.C.  
 19. July 13 19 47 Josephine Schaeffer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 19 47 at 11 A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-8 19 47 to 7-11 19 47  
 and that I last saw him alive on 3-8 19 47  
 Immediate cause of death Asthma  
 DURATION 14 days  
 Due to ① Generalized Arteriosclerosis 5 YRS.  
② Gastrovascular dysfunction 2 YRS.  
③ Generalized atherosclerosis 5 YRS.  
degenerative  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Verbit Stiles MD M. D. or other  
 Address 815 E. Cap St Date signed 7-11-47

RECEIVED  
JUL 15 1947  
BUREAU 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

178C

06147

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County MontgomeryCity or town Potomac  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Few hours

Hospital, institution, or street address where death occurred:

R. E. D. RockvilleHow long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County D. C.City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 144 Wayne Place, S. E.

(If rural, give LOCATION)

2.(a) If veteran, name war World War II

## 3.(a) FULL NAME

Ollie James Caughorn Jr.

## 3.(b) Social Security Number

578-16-7065

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Norma A. Caughorn6.(c) If alive, give age 25 yrs years

7. Birth date of

deceased (mo., day, yr.) December 12, 1919

8. AGE:

Years

Months

Days

It less than one day

2727714— hrs.— min.9. Birthplace Knoxville, Tenn.

(Town, county, and state)

10. Usual occupation Master Electrician11. Industry or business Electrician12. Name Ollie James Caughorn Sr.13. Birthplace Knoxville, Tenn.14. Maiden name Lena Kerr15. Birthplace Knoxville, Tenn.16. Informant Norma A. Caughorn (wife)Address Washington, D.C.17. Burial-Transit July 28, 1947  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory Knoxville CemeteryLocation Knoxville, Tenn.16. Funeral director Wm Raulen HumphreyAddress Bethesda, Maryland19. 7/27 19 47

(Date rec'd by registrar)

Wm E Jones Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1947 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1947 19 1947, 10 1947and that I last saw him alive on 19 1947Immediate cause of death Coronary thrombosis  
gassing

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 7-26-47Where did injury occur? Between Montgomery MD  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) farmMeans of injury gun in wall Injured at work? yes23. SIGNATURE Frank J. Bruchman MD M. D. or otherAddress Garthman MD Date signed 7-26-47

RECEIVED

AUG 2 1947

BUREAU C 8

Birth and Death  
06148216

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF STILLBIRTH**

16/c Reg. Dist. No. 06

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

**1. PLACE OF BIRTH:**

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
Street address, hospital, or institution:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
Length of mother's stay in County 1 day  
(How many years, or months, or days. SPECIFY WHICH)

**2. USUAL RESIDENCE OF MOTHER:**

State Virginia  
County Arlington  
City or town Arlington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4842B Sath 28th Street  
(If RURAL give LOCATION)

**3. Name of child** Baby Boy CRONENWETT

5. Sex male Philip Barr 6. Twin or triplet no

4. Date of birth JUL 31 1947 Hour 11:59 P.M.

7. No. of weeks pregnancy 36

**FATHER OF CHILD**

8. Full name Wilson Robertson CRONENWETT  
9. Color white 10. Age at time of this birth 34 yrs.  
11. Usual occupation U. S. Navy

**MOTHER OF CHILD**

12. Full maiden name Agnes Elizabeth MARTIN  
13. Color white 14. Age at time of this birth 36 yrs.  
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1  
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? no During labor? no

18. Pregnancy, complications of Rh Antibody increase

19. Labor: (a) Complications of no (b) Induced? no

20. (a) Was there an operation for delivery? no  
(b) State all operations, if any (Yes or No)

(c) Did child die before operation? no  
During operation? no

23. (a) Burial (b) Date thereof 8 4 47  
(Burial, cremation or removal) (month) (day) (year)  
(c) Cemetery or crematory Arlington National

24. (a) Funeral director W.W. Chambers  
(b) Address 1400 Chapin Street, NW, Wash., D.C.

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Erythroblastosis

(b) Maternal causes Rh negative mother + Rh positive father

22. I certify to the birth of this child who was born dead\* on the date and hour above stated.

Signature PAUL PETERSON, Capt. (MC) USN  
(Specify if M. D., midwife, or other)

Address U. S. NAVAL HOSPITAL, Bethesda, Md.

25. (a) 8/6/47 (b) Mary Charlotte Smith  
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)  
The above certificate has been examined by me.

D.C. Health Officer, per

\* See Instruction C on stub.

Child lived 18 hours 59 minutes

V. S. A10

RECEIVED  
AUG 13 1947  
BUREAU V. C.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 470x

## CERTIFICATE OF DEATH

Reg. Dist. No. 06149 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 5 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D.C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1908 17th St., S.E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war Sp.Am. ✓

### 3. (a) FULL NAME

CROW, John Jay

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced divorced  
6.(b) Name of husband or wife \_\_\_\_\_ 6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) March 1, 1879  
8. AGE: Years 68 Months 4 Days 0 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ohio  
(Town, county, and state)  
10. Usual occupation unemployed  
11. Industry or business \_\_\_\_\_

FATHER 12. Name George S. Crow dec. 13. Birthplace Ohio  
MOTHER 14. Maiden name Morrison, Nancy dec. 15. Birthplace Missouri

16. Informant son: Mr. Robert F. Crow  
Address Dunbar, Penn.

17. burial Date thereof 7-3-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Location Arlington, Va.

18. Funeral director W. W. CHAMBERS ELG.  
Address Georgetown, D. C.

19. 7-2- 19 47 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 1 July 19 47 at 4:05 P.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 June 19 47 to 1 July 19 47  
and that I last saw him alive on 1 July 19 47

Immediate cause of death Carcinoma - 2309  
Metastases to Bronchus  
DURATION known  
6 months

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions emaciation  
metastases  
(Include pregnancy within 3 months of death)

Major findings of operations Bronchoscopy biopsy  
same disease Date of op. Dec 1946  
Autopsy results same disease confirmed  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury J.A. Watters Injured at work? \_\_\_\_\_

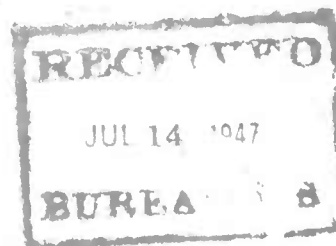
23. SIGNATURE J. E. WATERS, Lt.(jg)(MC) USNR  
M. D. or other \_\_\_\_\_  
Address USNH Bethesda, Md. Date signed 7-2-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

7/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

CG150

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Silver Spring, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... 12 years  
 Hospital, institution, or street address where death occurred:  
1000 Georgia Ave.  
 How long in hospital or institution?...

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery  
 City or town... Silver Spring, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Four Corners, R.F.D. #1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... No

## 3. (a) FULL NAME

AGNES IRENE CURRAN

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife... Robert M. deceased  
 6.(c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) Nov. 21, 1874  
 8. AGE: Years 72 Months 8 Days 27 If less than one day hrs. min.

9. Birthplace... Washington, D.C.  
 (Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business

FATHER 12. Name... William Poore  
 13. Birthplace... Washington, D.C.  
 MOTHER 14. Maiden name... Annie O'Neil  
 15. Birthplace... Washington, D.C.

16. Informant... Mr. Marrian D. CurranAddress... Four Corners, Silver Spring, Md

17. Burial Date thereof... July 21, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... St. Johns Catholic CemeteryLocation... Forest Glen, Maryland18. Funeral director... W. Eugene ThompsonAddress... Bethesda, Maryland

19. July 18 1947 Josephine W. Schaeff  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 18 July 1947 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
16 Dec 1946, to 18 July 1947  
 and that I last saw her alive on 17 July 1947

Immediate cause of death... Carcinoma of tongue  
 DURATION about 15 m.

Due to...

Due to...

Other conditions... Diabetes Mellitus  
Hypertension  
 (Include pregnancy within 8 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... William D. And, M.D.

Address... 9006 Lakeside Rd, Silver Spring, Md  
 Date signed... 18 July 47

RECEIVED  
JUL 25 1947  
BUREAU F.B.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4724

06151

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: Montgomery  
 County: 5008 Jamestown Rd. Md  
 City or town: Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
5008 Jamestown Rd.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State: Md County: Montgomery  
 City or town: Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.: 5008 Jamestown Rd  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Frank Crawford Davis

## 3. (b) Social Security Number

4. Sex: Male 5. Color or race: W 6. (a) Single, married, widowed, or divorced: Married  
 6. (b) Name of husband or wife: Gwendolyn Davis  
 7. Birth date of deceased (mo., day, yr.): Nov 7- 1886  
 8. AGE: Years: 60 Months: \_\_\_\_\_ Days: \_\_\_\_\_ If less than one day: \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace: Taylor Co. Md  
 (Town, county, and state)  
 10. Usual occupation: Elite Laundry - Sales  
 11. Industry or business

FATHER: 12. Name: Harry S. Davis  
 13. Birthplace: Mt. Airy, Md  
 MOTHER: 14. Maiden name: Kate Crawford  
 15. Birthplace: Mt Airy Md

16. Informant: Gwendolyn Davis (Wife)  
 Address: 5008 Jamestown Rd.

17. Burial Date thereof: 7/3/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory: Anisontown, Md  
 Location: The S. W. Norris Co

18. Funeral director: 2901-14 at NW  
 Address: 7/1 1947 Wm E Jones

19. (Date rec'd by registrar) 19. 47 Registrar: Wm E Jones

## MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 19. 47, at 3 A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 19. 46, to July 1 19. 47  
 and that I last saw him alive on July 1 19. 47

Immediate cause of death: Carcinoma lung  
 DURATION: 1 yr

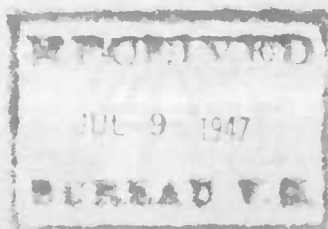
Due to: \_\_\_\_\_  
 Due to: \_\_\_\_\_  
 Other conditions: \_\_\_\_\_

(Include pregnancy within 3 months of death)  
 Major findings of operations: Carcinoma left lung  
Pneumothorax Date of op: 7/28/46

Autopsy results: \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide: \_\_\_\_\_ Date of: \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury: \_\_\_\_\_ Injured at work?

23. SIGNATURE: Walter W. Price M. D. or other  
 Address: 4918-Hillbrook Lane NW Date signed: 7/1/47



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

06152

Reg. Dist. No. 247

### 1. PLACE OF DEATH:

County Montgomery

City or town Stearns  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Damascus  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Mattie B. Day

### 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

married

8.(b) Name of husband or wife

James E. Day

7. Birth date of deceased (mo., day, yr.)

Dec. 18, 1872

6.(c) If alive, give age 85 years

8. AGE:

Years

Months

Days

If less than one day

74

6

25

hrs. min.

9. Birthplace

Near Kempton, Fred Co. Md.  
(town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

FATHER  
MOTHER

12. Name

John A. Malesworth

13. Birthplace

Maryland

14. Maiden name

Annia Clay

15. Birthplace

Maryland

18. Informant

William J. Day

Address

Damascus Md.

17.

(Burial, cremation, or removal, which?)

Burial

Date thereof

July 15, 1947  
(month) (day) (year)

Cemetery or crematory

Damascus

Location

Damascus Md.

18. Funeral director

J. B. Beall Inc.

Address

Damascus Md.

19.

(Date rec'd by registrar)

19.

47

Della W. Burdette  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1947 at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 22, 1943 to July 13, 1947

and that I last saw ER alive on July 8, 1947

Immediate cause of death intermyocardial coronary vascular disease

DURATION

15 yrs.

and Hypertension

4 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

James P. Kerr M.D.  
Address Damascus Md. Date signed 7/14/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 18 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 59a

## CERTIFICATE OF DEATH

06153

Reg. Dist. No. 714

## 1. PLACE OF DEATH:

County MONTGOMERYCity or town SILVER SPRINGS  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 MONTHSHospital, institution, or street address where death occurred:  
MRS MELTONS REST HOMEHow long in hospital or institution? 17 MONTHS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERYCity or town SILVER SPRINGS  
(If outside city or town limits, write RURAL and give nearest town)Street No. 9508-BILTMORE DR  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

ELBRETTE KATHRINE DIXON

## 3. (b) Social Security Number

## 4. Sex

FEMALE

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

WIDOWED

## 6. (b) Name of husband or wife

GEORGE L DIXON

## 7. Birth date of

deceased (mo., day, yr.)

APRIL 30 1888

## 6. (c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

5921

hrs.

min.

## 9. Birthplace

PENN.

(Town, county, and state)

## 10. Usual occupation

HOUSEWIFE

## 11. Industry or business

## FATHER

## 12. Name

UNKNOWN

## 13. Birthplace

UNKNOWN

## MOTHER

## 14. Maiden name

UNKNOWN

## 15. Birthplace

UNKNOWN

## 16. Informant

E. J. MAJORE

## Address

150-33RD ST. NE

## 17.

(Burial, cremation, or removal, Which?)

## Date thereof

(month) (day) (year)

## Cemetery or crematory

FT. LINCOLN

## Location

3801 BLASENSBORO RD.

## 18. Funeral director

Th. S. N. Shivers Co

## Address

2111 14th St. N.W.

## 19.

Date rec'd by registrar

19

47

Josephine N. Schaeffer

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 19 47 at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 19 47 to July 1 19 47and that I last saw her alive on July 1 19 47

Immediate cause of death

Coronary dilatation

DURATION

48 hr.

Due to

Strophic arthritis, confined to bed for 17 years

Due to

Other conditions

Extreme emaciation & debility  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm. A. Shuman M.D.

M. D. or other

Address

113 Carroll St. N.W.

Date signed

July 1, 47

RECEIVED

JUL 5 1947

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 days, 4 3/4 hrs.  
 Hospital, institution, or street address where death occurred:  
Washington San. Hospital  
 How long in hospital or institution? 2 days 4 3/4 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 45 Sycamore Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Evans, Mrs. Jeanette Marguerite

## 3. (b) Social Security Number

4. Sex Fe 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed.  
 6. (b) Name of husband or wife Mr. William James Evans  
 7. Birth date of deceased (mo., day, yr.) Jan. 17, 1860 6. (c) If alive, give age ..... years  
 8. AGE: Years 87 Months 6 Days 14 If less than one day ..... hrs. .... min.

9. Birthplace Kirksville, Mo.  
 (Town, county, and state)  
 10. Usual occupation At Home.  
 11. Industry or business  
 12. Name ANDRE STINSON  
 13. Birthplace FRANCE?  
 14. Maiden name Unknown  
 15. Birthplace IL

16. Informant Hospital Chart  
 Address

17. Burial Date thereof August 2, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory George Wash. Mem. Cem.  
Edge Road, Hyattsville, Md.  
 Location

18. Funeral director Wm. J. Miller  
 Address 254 Carroll St. W. Takoma Park, Md.

19. July 31, 1947 Registrar Wm. J. Miller  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 19 47 at 4<sup>09</sup> A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 19 47 to July 31 19 47  
 and that I last saw her alive on July 30 19 47  
 Immediate cause of death Coronary occlusion DURATION 2 1/2 days  
 Due to .....  
 Due to .....  
 Other conditions Advanced age  
 (Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. ....  
 Autopsy results .....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Raymond Ernscher MD  
 Address 6204 - 4th Pl. Riverdale Md. Date signed July 31, 47  
 (If M.D. or other)

RECEIVED  
AUG 1 1947  
BUREAU VE

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

06155

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: Mont. Co.  
County Chevy Chase, Maryland  
City or town 6603 Summit Avenue  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County  
City or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6603 Summit Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME  
Geraldine M. Fitzgerald

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Gerald  
6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) April 3, 1905  
8. AGE: Years 42 Months Days If less than one day  
.....hrs. ....min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business  
12. Name Harry A. Sager  
13. Birthplace Ohio  
14. Maiden name -- Porter  
15. Birthplace England

16. Informant Gerald Fitzgerald  
Address 6603 Summit Avenue, Ch.Ch.Md.

17. Burial Date thereof July 9, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory  
Location Herndon, Virginia

18. Funeral director The S. N. Wines Company  
Address 2901 14th St. N.W. Wash. D.C.

19. 7/7 19 47 Wm E Jones  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

2D. DATE OF DEATH July 7 19 47 at 10:45 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 19 47 to July 7 19 47  
and that I last saw her alive on July 14 19 47

Immediate cause of death  
General circumscription  
Due to Adeno-Carcinoma of  
Left Breast DURATION 2 yrs.  
Due to  
Other conditions

(Include pregnancy within 3 months of death)  
Major findings of operations Adeno-Carcinoma of  
Left Breast Date of op. 1945  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

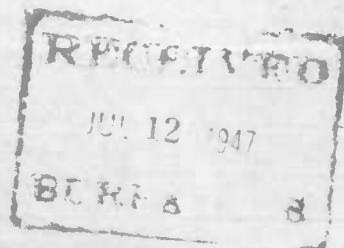
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE William E Jones M.D. or other  
Address 3921 Lippman St. Date signed 7/7/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

956

06156

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since July 21, 1947Hospital, institution, or street address where death occurred Suburban Hosp.  
8600 Old Georgetown Rd. Bethesda, Md.How long in hospital or institution? Since July 21, 1947

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 220 Elm St.  
(If rural, give LOCATION)2. (a) If veteran, name war No

## 3. (a) FULL NAME

Mr Albert H. France

## 3. (b) Social Security Number

217-22-5471

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Frances France

7. Birth date of

deceased (mo., day, yr.) Sept. 9, 1880

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

661022

hrs.

min.

9. Birthplace St. Joseph, Mo.

(Town, county, and state)

10. Usual occupation (Retired) Artist

11. Industry or business

FATHER

12. Name Charles France

13. Birthplace

Virginia

MOTHER

14. Maiden name Martha McDonald

15. Birthplace

St. Joseph, Missouri

18. Informant

Hospital Records

Address

Suburban Hospital, Bethesda, Md.

17.

Burial

Date thereof

August 2, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mt. Olivet Cemetery

Location

Washington, D. C.

18. Funeral director

Address

Bethesda, Maryland

19.

8/2  
(Date rec'd by registrar)

19.

47Wm E Jones  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 19 47 at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 10 19 47 to July 31 19 47and that I last saw him alive on July 30 19 47

Immediate cause of death

congestive heart failure  
uremia

DURATION

1 yr6 wks

Due to

post. rheumatic heart disease

Due to

20 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address 7852 16th St Waco Date signed 7/31/47

RECEIVED  
AUG 6 1947  
BUREAU V.2

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1642

## CERTIFICATE OF DEATH

S 06157  
Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 months, 6 days (staff)  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, NNMHC, Bethesda, Md.  
 How long in hospital or institution? 9 months, 6 days (staff)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Ohio County \_\_\_\_\_  
 City or town Dayton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 318 St. Paul Avenue  
 (If rural, give LOCATION) ✓

## 3. (a) FULL NAME

GAEKE, Jerome Francis

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) June 2, 1921 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 26 Months 1 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Dayton, Ohio  
 (Town, county, and state)

10. Usual occupation US Navy

11. Industry or business \_\_\_\_\_

FATHER 12. Name Carl J. Gaeko  
 13. Birthplace Ohio

MOTHER 14. Maiden name Frieda Niedenmeyer (stepmother)  
 15. Birthplace Ohio

16. Informant Father: Mr. Carl J. Gaeko  
 Address 318 St. Paul Avenue, Dayton, Ohio

17. burial Date thereof 7- -47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_  
 Location Dayton, Ohio

18. Funeral director W. W. CHAMBERS P. J. K.  
 Address 1400 Chapin St., N.W., Wash., D.C.

19. 7-16 47 Mary Charlotte Smith  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 15 July 19 47 at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 July 19 47, to 15 July 19 47

and that I last saw him in med. exam case 19 \_\_\_\_\_

Immediate cause of death Compound fracture of skull  
multiple fractures, throat  
due to falling  
suicide

## DURATION

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Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

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MARGIN RESERVED FOR BINDING

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9-45-15M

VS A15

7/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 29 1947  
BUREAU C. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06158

Reg. Dist. No. 213

## 1. PLACE OF DEATH:

County Montgomery  
 City or town RFD # 2, Rockville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 years  
 Hospital, institution, or street address where death occurred:  
RFD # 2, Rockville  
 How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town RFD # 2, Rockville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. RFD # 2, Rockville  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war No

## 3. (a) FULL NAME

ENEVER L. GALLAHAN

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Katie B. Gallahan  
 6. (c) If alive, give age Dec. years  
 7. Birth date of deceased (mo., day, yr.) August 22, 1872  
 8. AGE: Years 74 Months 11 Days 7 It less than one day hrs. min.

9. Birthplace Virginia  
 (Town, county, and state)  
 10. Usual occupation Retired  
 11. Industry or business None  
 12. Name Thomas Gallahan  
 13. Birthplace Virginia  
 14. Maiden name Unknown  
 15. Birthplace Unknown

16. Informant Leve H. King  
 Address RFD # 2, Rockville, Maryland  
 17. Burial July 31, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Oakdale Church Cemetery  
 Location Greenwich, Virginia  
 18. Funeral director Wm. Raulson Humphrey  
 Address Rockville Maryland  
 19. 7-30 47  
 (Date rec'd by registrar) 19. EP Shoup  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 29 July 19 47, at 24 M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 July 19 47 to 29 July 19 47  
 and that I last saw him alive on 28 July 19 47  
 Immediate cause of death Cerebral Thrombosis DURATION 10 yrs  
15 yrs

Due to Arteriosclerosis  
 Due to Hypertension  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE W.S. Murphy M.D. M. D. or other  
 Address Rockville Md Date signed 30 July 19 47

RECEIVED

AUG 2 1947

STEEL

3

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06159

Reg. Dist. No. 223

### 1. PLACE OF DEATH:

County Montgomery  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

35 Sycamore Ave.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia

City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3144 Oliver St NW  
(If rural, give LOCATION)

2.(a) if veteran, name war None

### 3. (a) FULL NAME

LILLIAN GILBERT

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife William Harvey Gilbert

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 16, 1858

8. AGE: Years 89 Months 4 Days 5 If less than one day hrs. min.

9. Birthplace Middleway, W. Virginia  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John William Grantham

13. Birthplace Jefferson County, W. Virginia

MOTHER 14. Maiden name Phebe LaRue

15. Birthplace Clark County, W. Virginia

16. Informant Mrs Earl Grantham

Address 3144 Oliver St. NW, Wash. DC

17. Burial Date thereof July 27, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Middleway

Location Middleway, West Virginia

18. Funeral director L. H. Hines Co.

Address 2901-14th St. N.W. D.C.

19. July 25, 47 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July - 24<sup>th</sup> 1947 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1947, to July - 24 1947.

and that I last saw him alive on July - 23 1947.

Immediate cause of death Myo. Cardiac

Insufficiency DURATION 3 weeks

Due to Acute Heart failure 1 hour

Due to Senility 89 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Logan Overier, M.D.

Address 1316 7th St. NW - Wash. DC Date signed 7-24/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7/24/47

Approved by Dr Frank J. Broschart

Montgomery County Coroner.

S. Logan Currier, M.D.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Dist. No. 06160 216

### 1. PLACE OF DEATH:

County Montgomery  
 City or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months  
 Hospital, institution, or street address where death occurred:  
Chevy Chase Country Club  
 How long in hospital or institution? None

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Bethesda 14,  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4506 Harling Lane  
(If rural, give LOCATION)  
None  
 2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

DANIEL LANDMESSER GOELTZ

### 3. (b) Social Security Number

unknown

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>White</u>	<u>Widowed</u>

6. (b) Name of husband or wife Harriet M. Goeltz

7. Birth date of deceased (mo., day, yr.) May 9, 1872

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>1</u>	<u>22</u>	— hrs. — min.

9. Birthplace Wilkes-Barre, Pa.  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Carpet Salesman

12. Name Jacob Goeltz  
 13. Birthplace Germany

14. Maiden name Harriet Landmesser  
 15. Birthplace Ashley, Pa.

16. Informant Frank M. Goeltz (son)  
 Address Bethesda 14, Maryland

17. Burial-Transit Date thereof July 2, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Hollenback Cemetery  
 Location Wilkes-Barre, Pa.

18. Funeral director Wm. Leiman Pumphrey  
 Address Bethesda, Maryland

19. 7/2 19 47 9pm E Jones  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st, 19 47 at 8:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_\_, and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_\_.  
 Immediate cause of death Dep. Med. Exam. Case DURATION \_\_\_\_\_

Coronary occlusion died suddenly  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_  
 \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 \_\_\_\_\_  
 \_\_\_\_\_ Date of \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Frank J. Bruchart M.D. M. D. or other \_\_\_\_\_  
Dep. med. Exam.  
 Address Gaithersburg, Maryland Date signed 7/1/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 12 1947  
BUREAU OF A

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 06161  
216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 month, 28 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 1 mo., 28 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va. County \_\_\_\_\_  
City or town Arlington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1300 N. Pierce St., Apt. 104  
(If rural, give LOCATION)  
2. (a) If veteran, name war WW2 ✓

### 3. (a) FULL NAME

GOODLET, Andrew Melvin

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs. Patricia Goodlet

7. Birth date of deceased (mo., day, yr.) 16 August 1924

8. AGE: Years 22 Months 11 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Georgia  
(Town, county, and state)

10. Usual occupation unemployed

11. Industry or business \_\_\_\_\_

12. Name GOODLET, William A.

13. Birthplace Ga.

14. Maiden name BYRD, Miranda dec.

15. Birthplace Ga.

16. Informant Wife: Mrs. Patricia Goodlet

Address 1300 N. Pierce St., Apt. 104, Arl., Va.

17. burial Date thereof 7-21-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. CHAMBERS W. J. T.

Address 517 11th St., S.E., Wash., D.C.

19. 7-18 19 47 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 18 July 19 47 at 7:30A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 May 19 47, to 18 July 19 47, and that I last saw him alive on 18 July 19 47.

Immediate cause of death Sarcoma: fibro-fibrous DURATION 3 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations same

Autopsy results negative

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE C. H. C. Smith, Cor. (MC) USN

Address USNH Bethesda, Md. M. D. or other \_\_\_\_\_

Date signed 7-18-47

MARGIN RESERVED FOR BINDING

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VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7/23/47

RECEIVED  
JUL 29 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06162

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Rockville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 yearsHospital, institution, or street address where death occurred:  
105 S. Washington St.-RockvilleHow long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 105 S. Washington St.  
(If rural, give LOCATION)2(a) If veteran, name war No

## 3. (a) FULL NAME

Hope Summers Greene

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed6. (b) Name of husband or wife Edward L. GreeneMay 29, 1887 6. (c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) May 29, 18878. AGE: Years Months Days If less than one day  
60 1 26 - hrs. - min.9. Birthplace Louden County Virginia  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business none12. Name William S. Summers13. Birthplace Fairfax County, Virginia14. Maiden name Mammy L. Woods15. Birthplace Virginia18. Informant Mary Hope FinleyAddress Alber, N. Mexico17. Burial Date thereof Sun. July 27  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rockville Union CemeteryLocation Rockville, Maryland18. Funeral director Wm. Reuben RumphreyAddress Rockville, Maryland19. 7/26 47 Wm E Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 19 47 at 4:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 19 47 to July 25 19 47and that I last saw him alive on July 25 19 47Immediate cause of death Carcinoma of stomachDURATION 6 monthsDue to -Due to -Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of stomach,  
inoperable. Date of op. June 26, 1947Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. E. Jones M.D. M. D. or otherAddress Rockville, Md. Date signed 7/26/47

RECEIVED  
AUG 2 1947  
BUREAU V.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06163

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County... Montgomery  
City or town... Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 16 days  
Hospital, institution, or street address where death occurred:  
U. S. Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 16 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... Maryland County... Montgomery  
City or town... Silver Springs  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 10015 Brunette Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war... WW II

### 3. (a) FULL NAME

HAFFERMAN, Clarence Anthony

### 3. (b) Social Security Number

4. Sex... male 5. Color or race... white 6.(a) Single, married, widowed, or divorced... married  
6.(b) Name of husband or wife... Mrs. Marion Hafferman  
7. Birth date of deceased (mo., day, yr.) 22 October 1905 6.(c) If alive, give age... years  
8. AGE: Years... 41 Months... 8 Days... 24 If less than one day... hrs. ... min.

9. Birthplace... Washington, D. C.  
(Town, county, and state)

10. Usual occupation... Bookkeeper-Cashier

11. Industry or business... Montgomery County

12. Name... John Hafferman

13. Birthplace... Alaska, dec.

14. Maiden name... Agnes Thomas

15. Birthplace... Washington, D. C.

16. Informant... Wife: Mrs. Marion Hafferman

Address... 10015 Brunette Ave., Silver Springs, Md.

17. burial Date thereof... 7-18-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Arlington National Cemetery

Location... Arlington, Virginia

18. Funeral director... S.H. HINES CO W. A. S.

Address... 2901 14th Street, NW, Washington, D. C.

19. 7-16 47 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH... 16 July 19 47 at 1:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-30 19 47 to 7-16 19 47

and that I last saw him alive on 7-16 19 47

Immediate cause of death... CORONARY THROMB-

OSIS WITH MYOCARDIAL

INFARCTION

Due to... ARTERIOSCLEROSIS,

CORONARY ARTERY

Due to...

Other conditions... None

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results... NOT GRANTED BY FAMILY

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

Signature... J. BRYAN LTJG MC USNR

23. SIGNATURE... USNH, BETHESDA, MD.

Date signed...

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

7/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 29 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

## CERTIFICATE OF DEATH

06164

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 100-Cedar Ave.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Arthur Percy Harris

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

B.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 22, 1887 6.(c) If alive, give age ..... years

8. AGE: Years 69 Months 10 Days 20 If less than one day ..... hrs. .... min.

9. Birthplace Washington D.C.  
 (Town, county, and state)

10. Usual occupation Art Director-Sears & Roebuck

11. Industry or business

12. Name Jacob P. Harris  
 13. Birthplace Washington D.C.

14. Maiden name Margaret Helen Roswell  
 15. Birthplace Washington, D.C.

16. Informant Margaret Helen Harris  
 Address 100-Cedar Ave. Takoma Park, Md.

17. Burial Date thereof 7/15/47  
 (Burial, cremation, or removal. Which?) (month)/(day) (year)

Cemetery or crematory Congressional Cem.  
 Location Washington D.C.

18. Funeral director The H. H. Hines Co.  
 Address 2901-14th St. N.W.

19. 7/12/47 19 47 Wm E Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1947 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

20 years 19 27  
 and that I last saw him alive on June 38 19 47

Immediate cause of death

Coronary Thrombosis DURATION 1 hr

Due to

Due to

Other conditions Menstrual disorder many years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

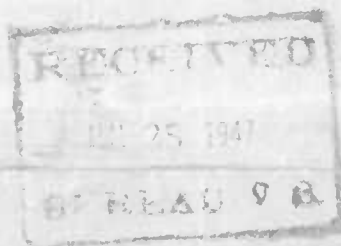
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James J. Gray, M.D. M. D. or other

2009 Calverton Rd Address Date signed July 12/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County..... Montg Co,  
 City or town..... Washington Grove,  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 33 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Montg  
 City or town..... Washington Grove  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Andrew W. Heil

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Myra B Heil

7. Birth date of deceased (mo., day, yr.) 8. AGE: Years Months Days If less than one day

May 24th 1866 81 1 21 hrs. min.

9. Birthplace All-ance Ohio

10. Usual occupation Retired, Police Desk Clerk

11. Industry or business

12. Name Henry Heil

13. Birthplace Germany

14. Maiden name Christie Mathew

15. Birthplace Ohio

16. Informant Mrs Myra B Heil

Address Washington Grove, Md,

17. Burial Date thereof 7/17/47

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Washington, D C,

Location

18. Funeral director Ernest C Gartner

Address Gaithersburg Md,

19. Date rec'd by registrar July 16 1947

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 15th 1947 at 8-16AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1937 to July 15, 1947

and that I last saw him alive on July 14, 1947

Immediate cause of death Cerebral arterio

sclerosis - Thrombosis

Cerebral blood vessel

Due to General arterio-sclerosis

Cardio-vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Upton D. Houser M.D.

Address Danville Ind. Date signed 7/16/47

RECEIVED  
JUL 18 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 716

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Petersburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital  
 How long in hospital or institution? 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)  
 State Maryland County Montgomery  
 City or town P. O. #1  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. German Town  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Nettie Hinchley

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow  
 6.(b) Name of husband or wife Sidley  
 7. Birth date of deceased (mo., day, yr.) May 13, 1877  
 6.(c) If alive, give age ..... years  
 8. AGE: Years 74 Months 2 Days 15 If less than one day ..... hrs. .... min.

9. Birthplace Ohio  
 (Town, county, and state)  
 10. Usual occupation Zimmerman - Housework  
 11. Industry or business Earl Groom

12. Name Elizabeth Karafthefer  
 13. Birthplace Germany  
 14. Maiden name William Hinchleyson  
 15. Birthplace same

16. Informant same  
 Address same  
 17. Burial Date thereof 7 30 47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Goshen  
 Location near Laytonville Md  
 18. Funeral director Ray W Barber  
 Address Laytonville Maryland

19. 7/29 19 47 Wm E Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1947 at 3:45 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to July 28, 1947  
 and that I last saw him alive on July 28, 1947

Immediate cause of death  
MASSIVE HEMORRHAGE FROM  
RUPTURED BLOOD VESSEL BASE OF BRAIN  
 Due to ARTERIOSCLEROSIS  
 Due to .....  
 Other conditions PNEUMONIA LEFT LUNG  
 (Include pregnancy within 3 months of death)

## DURATION

3 days15 YEARS2 days

Major findings of operations ..... Date of op. ....  
 Autopsy results AS ABOVE  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? ..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work? .....  
 23. SIGNATURE William Welch M.D.  
 Address Rockville, Md M. D. or other  
 Date signed 7/29/47

RECEIVED

AUG 2 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

501

06167

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

## 1. PLACE OF DEATH:

County... MONTGOMERY

City or town... ROCKVILLE  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

101 NORTH VAN BUREN ST

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... MONTGOMERY

City or town... ROCKVILLE  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 101 N. VAN BUREN

(If rural, give LOCATION)

2.(a) If veteran, name war... No

## 3. (a) FULL NAME

MTS LISA

## 3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

OTTO

7. Birth date of

deceased (mo., day, yr.) Nov 21st - 1886.

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

60

7

28

hrs.

min.

9. Birthplace

GERMANY

(Town, county, and state)

10. Usual occupation

WRITER

11. Industry or business

FATHER  
MOTHER

12. Name

EUGENE LOEWE

13. Birthplace

GERMANY

14. Maiden name

BIANGLIA STERNBERG

15. Birthplace

GERMANY

16. Informant

DR KARL WELTE

Address 101 N VAN BUREN ST ROCKVILLE MD

17.

BURIAL

Date thereof JULY 22 - 1947

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

ST. MARY'S

Location

ROCKVILLE, MONTG. Co. MD

18. Funeral director

Wm. E. Humphrey

Address

SILVER SPRING, MD.

19.

7-22

19

47

(Date rec'd by registrar)

E. Thompson

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... July 19 1947, at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 22 1947, to July 19 1947.

and that I last saw him alive on July 18 1947.

Immediate cause of death

Lymphosarcomatosis

DURATION

7 years

Due to

involvement of right breast, duodenum, subcutaneous nodules, orbit, etc.

Due to

Other conditions

Chronic myocarditis with decompensation  
(Include pregnancy within 3 months of death)

Major findings of operations

Right mastectomy - 1941  
Lobectomy - 1945

Autopsy result

None Biopsy - 1947

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

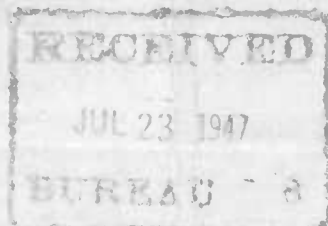
23. SIGNATURE

Wm. E. Humphrey M.D.

Address

Rockville, Md.

Date signed 7/19/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 161a

## CERTIFICATE OF DEATH

06168  
Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4568 Lily Ponds Drive, N.E.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

HUGHEY, Donner Yvonne

## 3. (b) Social Security Number

4. Sex <u>female</u>	5. Color or race <u>W-US</u>	6. (a) Single, married, widowed, or divorced <u>single</u>
6. (b) Name of husband or wife _____		
7. Birth date of deceased (mo., day, yr.) <u>21 June 1947</u>		
8. AGE: Years	Months	Days
		<u>12</u> hrs. min.
9. Birthplace <u>Md.</u> (Town, county, and state)		
10. Usual occupation _____		
11. Industry or business _____		
12. Name <u>HUGHEY, Sherman Moscoe, GMlc USN</u>		
13. Birthplace <u>Ala.</u>		
14. Maiden name <u>BAILEY, Mable Irene</u>		
15. Birthplace <u>Ala.</u>		

16. Informant Mother: Mrs. Mable I. Hughey  
 Address 4568 Lily Ponds Drive, N. E., Wash., D.C.  
 17. burial Date thereof 7-3-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.  
 18. Funeral director W. W. CHAMBERS  
 Address 1400 Chapin St., N.W., Wash., D.C.  
 19. 7-3- 19 47 Mary Charlotte Smith  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2 July 19 47 at 5:45 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
21 June 19 47 to 2 July 19 47  
 and that I last saw h er alive on 2 July 19 47

Immediate cause of death Atelectasis  
 Due to Aspiration of formula after regurgitation  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results Confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE PAUL PETERSON, Capt. (MC) USN  
 M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 7-3-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 14 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

06169

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County MontgomeryCity or town Piney, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 daysHospital, institution, or street address where death occurred:  
The Montgomery County General Hospital, Inc.How long in hospital or institution? 16 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Derwood  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mrs. Hortense Hunter

## 3. (b) Social Security Number

how

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife George M. Hunter

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) October 13, 18768. AGE: Years 70 Months 9 Days 1 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Germanstown, Maryland  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Josiah Dansey13. Birthplace Gaithersburg, Maryland14. Maiden name Valeria Pamphrey15. Birthplace Maryland16. Informant Hospital records

Address \_\_\_\_\_

17. Burial Date thereof July 16, 1947  
(Burial, cremation, or removal (Which?)) (month) (day) (year)Cemetery or crematory Rockville Union Cem.Location Rockville, Ind.18. Funeral director Wm. Reuter-SpangenbergAddress Rockville, Ind.19. 7-14- 19 47 Esther B. Lawler

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 19 47 at 6 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 19 47, to July 14 19 47and that I last saw her alive on July 14 19 47Immediate cause of death acute Cardiac Failure DURATION 2 hrsDue to Chronic Myocarditis

Due to \_\_\_\_\_

Other conditions Splenectomy done

(Include pregnancy within 3 months of death)

Major findings of operations Enlarged Spleenundiscovered Date of op. 7/12/47

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE JMB M. D. or other \_\_\_\_\_Address Sandy Spring, Md. Date signed 7/14/47

RECEIVED  
AUG 5 1947  
BUREAU C B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 870

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

06170

## 1. PLACE OF DEATH:

County... MontgomeryCity or town... Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... MontgomeryCity or town... Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No... 4619 Montgomery Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Ray Thompson Jenkins

## 3. (b) Social Security Number

578-10-5254

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

Estelle Fox

7. Birth date of deceased (mo., day, yr.)

April 3 18786. (c) If alive, give age 55 years

8. AGE:

Years

69

Months

2

Days

0

If less than one day

hrs. min.

9. Birthplace

Cumberland County, Pa.  
(Town, county, and state)

10. Usual occupation

W.D. Superintendent CTC.

11. Industry or business

Street Railway

MOTHER FATHER

12. Name

John Walth Jenkins

13. Birthplace

Virginia

14. Maiden name

Judith Ann Bowman

15. Birthplace

Virginia

16. Informant

Walth Jenkins

Address

31 So Mount St. Mountain Dr

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

7/5/47  
(month) (day) (year)

Cemetery or crematory

Fort Lincoln

Location

Bladenburg, Md.

18. Funeral director

Capital City

Address

5406 Bell Ave. N.W.

19.

(Date rec'd by registrar)

19.

477/11/47Wm E Jones

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... July 1, 1947 21. 8A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 22 1947 to July 1, 1947and that I last saw him alive on July 1, 1947

Immediate cause of death

acute cardiac failure

DURATION

1 day

Due to

Due to

Other conditions

Parkinson's disease15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ernest G. Buerstedt, Jr.

Address

Bethesda, Md.

Date signed

7/11/47

RECEIVED  
JUL 12 1947  
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH <sup>1600</sup> BIRTH AND DEATH 216  
**CERTIFICATE OF STILLBIRTH** Reg. Dist. No. <sup>06171</sup>

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street address, hospital, or institution:  
US Naval Hospital, Bethesda, Md.  
 Length of mother's stay in County 1 day  
 (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Washington, D. C.  
 County \_\_\_\_\_  
 City or town \_\_\_\_\_  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 15 Barnacle Green, S.W.  
 (If RURAL give LOCATION)

3. Name of child JUSTICE, John William

4. Date of birth 7-29-1947 Hour 12:13 P.M.

5. Sex Male 6. Twin or triplet no

7. No. of weeks pregnancy 9 months

FATHER OF CHILD

8. Full name JUSTICE, John William  
 9. Color W-US 10. Age at time of this birth 24 yrs.  
 11. Usual occupation Navy

MOTHER OF CHILD

12. Full maiden name ANDERSON, Shirley Elizabeth  
 13. Color W-US 14. Age at time of this birth 22 yrs.  
 15. Usual occupation housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0  
 (b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? NO During labor? NO

18. Pregnancy, complications of \_\_\_\_\_

19. Labor: (a) Complications of yes - Cord about neck 3 times - (b) Induced? \_\_\_\_\_

20. (a) Was there an operation for delivery? NO  
 (b) State all operations, if any \_\_\_\_\_  
 (Yes or No)

(c) Did child die before operation? \_\_\_\_\_  
 During operation? \_\_\_\_\_

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Asphyxia - Due to Cord about neck -  
 (b) Maternal causes \_\_\_\_\_

22. I certify to the birth of this child who was born dead\* on the date and hour above stated.

Signature PAUL PETERSON, Capt. (MC) USN  
 (Specify if M. D., midwife, or other)

Address USNH Bethesda, Md.

23. (a) burial (b) Date thereof \_\_\_\_\_  
 (Burial, cremation or removal) (month) (day) (year)  
 (c) Cemetery or crematory St. Mary's Cem., Balti. Md.

25. (a) 7-30-47 (b) Mary Charlotte Smith  
 (Date rec'd by registrar) (Registrar)

24. (a) Funeral director W. W. Chambers co. W. J. T.  
 (b) Address 1400 Chapin Street, NW, Wash., D.C.

26. (To be filled out if no physician was present at delivery.)  
 The above certificate has been examined by me.

Health Officer, per \_\_\_\_\_

\* See Instruction C on stub.

Baby lived: 27 hours, 13 minutes

V. S. A10

8/5/47

RECEIVED  
AUG 13 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

06172

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery Co., Md.City or town Cherry Chase, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Cherry Chase, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 14 Hesketh St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Trina Gonzalez Kjellesvig

## 3. (b) Social Security Number

no4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Magne Kjellesvig6. (c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) Feb 19, 18828. AGE: Years 65 Months 6 Days 1 It less than one day

hrs. min.

9. Birthplace Havana, Cuba  
(Town, county, and state)10. Usual occupation at home

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Mrs. Francis CraigAddress 14 Hesketh St. Ch. Ch.17. Burial Date thereof July 22, 1947  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Ft. Lincoln Md.Location Bladensburg Md. at D.C. Line18. Funeral director Cherry Chase Funeral HomeAddress 5103 Wisconsin Ave. N.W. Wash. D.C.19. 7/21 19 47 9pm E. Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 19 47 at 2:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 19 47 to 19and that I last saw him alive on July 20 19 47Immediate cause of death Cerebrovascular HemorrhageDue to Hypertensive Cardiovascular Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

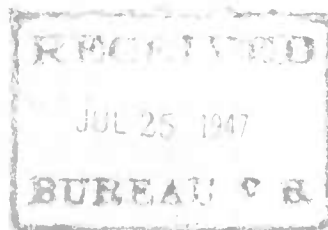
Means of injury Injured at work?

23. SIGNATURE J. L. Marks, M.D.Address 6306 Wisconsin Ave. Date signed 7/20/47

6.612

1.101.8  
1.101.8

1.101.8  
1.101.8



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 465X

## CERTIFICATE OF DEATH

06173

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one day

Hospital, institution, or street address where death occurred:

117 Grafton St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D C

County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3217 Wisconsin Ave. N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Charlotte Elizabeth Klein

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

Feb. 17, 1896

## 6. (c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

51 ?

hrs.

min.

## 9. Birthplace

Washington D C

(Town, county, and state)

## 10. Usual occupation

Organist

## 11. Industry or business

## FATHER

12. Name John Klein13. Birthplace Baltimore Md.

## MOTHER

14. Maiden name Caroline Weissmuller15. Birthplace Germany16. Informant Mrs. Marguerite M. KleinAddress 117 Grafton St.

## 17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

July 7 1947

(month) (day) (year)

Cemetery or crematory

Congressional Cemetery

Location

Washington D.C.

## 18. Funeral director

Address

J. William Lee's Sons Co  
3706 - 4th St NE Washington D.C.  
9/5 Am E. Jones

## 19.

(Date rec'd by registrar)

9/5 1947

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 419 47 at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 119 47 toJuly 419 47and that I last saw her alive on July 3 19 47

Immediate cause of death

Carcinoma of  
Pancreas with  
extensive metastases

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Carcinoma of  
PancreasDate of op. 6/6/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter B. Bonar

M. D. or other

Address

3921 Wisconsin Ave NW

Date signed

7/4/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 12 1947  
BUREAU OF A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06174

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 weeks  
 Hospital, institution, or street address where death occurred:  
10,000 Ga. Ave., Maple Lane Home  
 How long in hospital or institution? 2 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Apt. 110- 3100 Conn. Ave., N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Margaret Estelle Leeko

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Arthur W. Leeko  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) January 11 1871  
 8. AGE: Years 76 Months 6 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Queenstown, Maryland.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At home

12. Name Benjamin F. Sherwood  
 13. Birthplace Queenstown, Md.

14. Maiden name Suse Lenora Spear  
 15. Birthplace Queenstown, Maryland

16. Informant Mrs. William W. Paca  
 Address 6801 Exeter Road, Bethesda, Md.

17. Burial Date thereof July 16, 1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Glenwood Cemetery  
 Location Washington, D.C.

18. Funeral director The S. W. Hines Company  
 Address 2901 14th St., N.W. D.C.

19. Date rec'd by registrar July 14 19 47 Registrar Joseph H. Schaeffer

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 19 47 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13, 19 47 to July 14, 19 47 and that I last saw her alive on July 13, 19 47

Immediate cause of death Cerebral hemorrhage DURATION 30 hrs.

Due to Hypertension + Cerebral arteriosclerosis 15+ yrs.

Due to \_\_\_\_\_  
 Other conditions Terminal pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results not done  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Jamae Long, M.D. M. D. or other  
 Address 4822 Cherry Chase Dr. Date signed 7-14-47

cleared with Dr. Brochard, - coroner,  
Montgomery Co, Md.

July 13, '47.

James H. Longfellow

Longfellow



Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

06175

214

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 7719 Eastern Ave  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7719 Eastern Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....  
 6. (b) Name of husband or wife.....  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.).....  
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace.....  
 (Town, county, and state)  
 10. Usual occupation.....  
 11. Industry or business.....  
 12. Name.....  
 13. Birthplace.....  
 14. Maiden name.....  
 15. Birthplace.....

16. Informant.....  
 Address.....  
 17. (Burial, cremation, or removal. Which?)..... Date thereof.....  
 Cemetery or crematory.....  
 Location.....  
 18. Funeral director.....  
 Address.....  
 19. Date rec'd by registrar..... 19. 47 Josephine M. Schaeffer

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 19. 47, at 11:00 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... to.....  
 and that I last saw him..... alive on.....  
 Immediate cause of death.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

## DURATION

Coronary occlusion  
 Due to.....  
 Due to.....  
 Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town)..... (County)..... (State).....  
 Injured at home, farm, industry, public place (where?).....  
 Means of Injury..... Injured at work?  
 23. SIGNATURE..... M. D. or other.....  
 Date signed.....

RECEIVED

JUL 10 1947

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 133a

## CERTIFICATE OF DEATH

06176  
Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 mos., 3 days  
Hospital, institution, or street address where death occurred:  
U. S. Naval Hospital, Bethesda, Maryland  
How long in hospital or institution? 3 mos., 3 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D. C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2101 New Hampshire Avenue, Northwest  
(If rural, give LOCATION)  
2(a) If veteran, name war unknown

### 3. (a) FULL NAME

MANSFIELD, Joseph Jefferson

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower

6. (b) Name of husband or wife widower

7. Birth date of deceased (mo., day, yr.) 9 February 1861 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 86 Months 5 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace West Virginia  
(Town, county, and state)

10. Usual occupation Congressman

11. Industry or business House of Representatives

12. Name Joseph J. Mansfield

13. Birthplace Virginia

14. Maiden name Amanda Smith

15. Birthplace Virginia

16. Informant Son: Mr. Bruce J. Mansfield

Address 2101 New Hampshire Ave., NW, Wash., DC

17. removal Date thereof 7-12-47  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetary or crematory \_\_\_\_\_

Location Eagle Lake, Texas

18. Funeral director S. H. Hines Co. W.A.S.

Address 2901 14th St., NW, Washington, D. C.

19. JUL 12 1947 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 12 July 19 47 at 1:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-9- 19 47, to 7-12- 19 47  
and that I last saw him alive on 7-12- 19 47

Immediate cause of death \_\_\_\_\_

arteriosclerosis general 10 years

Due to pyelonephritis 2 years

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. \_\_\_\_\_

Autopsy results arteriosclerosis - pyelonephritis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury fall Injured at work? \_\_\_\_\_

23. SIGNATURE H.V. PACKARD, CAPT MC USN

Address U.S. NAVAL HOSPITAL, BETHESDA

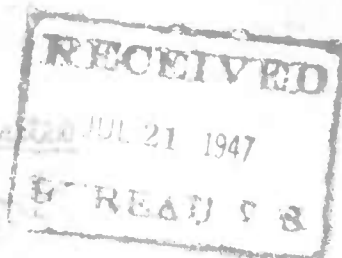
Date signed JUL 12 1947

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7/17/47



may 14  
may 14

*Journal of American Studies*  
*Vol. 11, No. 1*

*Journal of American Studies*  
*Vol. 11, No. 1*

*Journal of American Studies*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 486 X

## CERTIFICATE OF DEATH

06177

Reg. Diat. No. 223

## 1. PLACE OF DEATH:

County Montgomery CountyCity or town Takoma Park Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2

Hospital, institution, or street address where death occurred:

Washington Sanitarium & HospitalHow long in hospital or institution? 209 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 28 Lincoln Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Marmaduke Mrs Mary E.

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife?

7. Birth date of deceased (mo., day, yr.)

September 1, 1854

8. AGE: Years Months Days If less than one day

92 10 0 2 hrs. min.9. Birthplace Washington D.C.  
(Town, county, and state)10. Usual occupation None11. Industry or business None12. Name Francois LaBarre13. Birthplace France14. Maiden name Marie Burkhardt15. Birthplace Washington D.C.16. Informant Hospital Records

Address

17. Burial Date thereof 7/31/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Congressional CemLocation Washington D.C.18. Funeral director The P. W. Jones CoAddress 2901-14 St. N.W.19. July 1 19 47  
(Date rec'd by registrar)

Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 19 47 at 2:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 4 19 46 to July 1 19 47and that I last saw her alive on July 30 19 47Immediate cause of death Coronary Occlusion

DURATION

TerminalDue to Arteriosclerosis Years

Due to

Other conditions Carcinoma of Uterus One year

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert A. Hare M.D.

M. D. or other

Address Takoma Park Md.Date signed 7/1/47

RECEIVED

JUL 7 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

06178

223

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Silver Spring, Montgomery Co.City or town Silver Spring, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Wash. San. & Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery Co.City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 9602 Georgia Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME CAROLYN

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

October 25, 1944

8. (c) If alive, give age years

8. AGE:

2 Years9 Months

Days

If less than one day

hrs.

min.

9. Birthplace Washington San., Takoma Park, Md.  
(Town, county, and state)10. Usual occupation child

11. Industry or business

FATHER

12. Name

Walter M. Miller

13. Birthplace

Montgomery Co., Maryland

MOTHER

14. Maiden name

Marjorie Lois Talbot

15. Birthplace

Montgomery Co., Maryland

16. Informant

Mrs. William Talbot, grandmother

Address

9602 Georgia Ave., Silver Spring, Md.17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof

July 28-1947

Cemetery or crematory

COLESVILLE METHODIST CHURCH

Location

COLESVILLE - MONTG. CO. - MD.

18. Funeral director

Edmund E. Humphrey

Address

SILVER SPRING, Md.19. July 25-47

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 19 47 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sip. med. exam. caseand that I last saw him alive on 19

Immediate cause of death

Inter. cranial hemorrhageDue to fractures of skull

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-26-47Where did injury occur? Silver Spring, Montg. Co., Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury struck by auto Injured at work? no23. SIGNATURE Frank J. Bruchart M.D.Address Sip. med. exam. case M. D. or otherDate signed 7-26-47

RECEIVED  
JUL 30 1960  
BERKELEY, CA

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

## CERTIFICATE OF DEATH

06179

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months  
 Hospital, institution, or street address where death occurred:  
8497 Rockville Pike  
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 8497 Rockville Pike  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war No

## 3. (a) FULL NAME

Minerva Jane Mitchell

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Richard P. Mitchell

## 7. Birth date of deceased (mo., day, yr.)

July 7, 1869

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

780153 hrs. \_\_\_\_\_ min.9. Birthplace Fayette County, Pa.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business NoneFATHER  
MOTHER12. Name John B. Stauffer13. Birthplace Scottdale, Pa.14. Maiden name Catherine Myers15. Birthplace Mt. Pleasant, Pa.16. Informant Richard D. MitchellAddress 8497 Rockville Pike, Bethesda Md.17. Burial Date thereof July 26/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Taylorville CemeteryLocation Taylorville, Md.18. Funeral director W. Reuben ThompsonAddress Bethesda, Maryland19. 7/23 47 Wm E Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947 at 6:00 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

day and hour 1947 to \_\_\_\_\_ 19\_\_\_\_\_  
 and that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_\_  
 Immediate cause of death Coronary occlusion

## DURATION

Found dead in home

Due to \_\_\_\_\_Due to \_\_\_\_\_Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

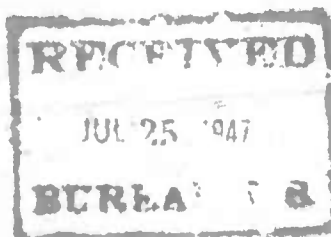
Major findings of operations \_\_\_\_\_Date of op. \_\_\_\_\_Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)Injured at home, farm, industry, public place (where?) \_\_\_\_\_Means of injury \_\_\_\_\_Injured at work? \_\_\_\_\_23. SIGNATURE Frank J. Brumhart M.D. M. D. or other

Y. J. Jones md Date signed 7-22-47  
 Address \_\_\_\_\_



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

06180

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1106 Flower Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3.(a) FULL NAME

Patti Strayer Morrison

## 3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1935

8. AGE: Years Months Days If less than one day

12 5 15 hrs min  
 9. Birthplace Takoma Park, Md.  
 (Town, county, and state)

10. Usual occupation Student

11. Industry or business

12. Name Keith G. Morrison13. Birthplace Fort Smith, Ark.14. Maiden name Larissa Matheson15. Birthplace Washington, D. C.16. Informant MotherAddress 1106 Flower Ave Takoma Park17. Burial Date thereof July 9, 1947

(Burial, cremation, or removal. When)

Cemetery or crematory Green Staff Memorial Cem.Location 2 Arthur St.18. Funeral director 257 Carroll St. S. P.Address 7/8/47

19. (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947 at 2:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

(Anney) 1947 to 1947and that I last saw him alive on 1947Immediate cause of death Glomerular nephritisDURATION 2 mo.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

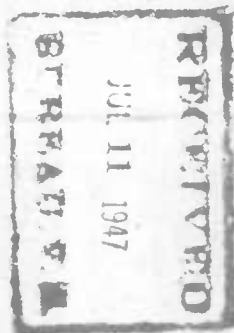
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Marion Boushead MDAddress 9601 Sutton Rd. M. D. or otherDate signed 7/7/47

Has been under care of Dr. H. B. Queen, 112  
Willow ave. Tokona Park, Md. for past 2 months.  
Dr. Queen left on his vacation yesterday 7/6/47,  
and left it under my care; pt. died without  
my having had chance to see her since  
Dr. Queen left. Dr. Broschardt, County Coroner,  
authorized my issuing this certificate.  
July 7, 1947  
J. Marion Bauschard Md.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06181

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

## 1. PLACE OF DEATH

County Mont.  
 City or town no place - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 years  
 Hospital, institution, or street address where death occurred:  
no  
 How long in hospital or institution? no

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Mont  
 City or town rural - Olney  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rockville Rd  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

Mary E. Offutt

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Col 6.(a) Single, married, widowed, or divorced Housewife

6.(b) Name of husband or wife Sam E. Offutt7. Birth date of deceased (mo., day, yr.) July 4 - 18898. AGE: Years 58 Months 0 Days 19 If less than one day9. Birthplace Mont Co Md10. Usual occupation housewife - own home

11. Industry or business

12. Name Nicholas Randolph13. Birthplace Mont Co Md14. Maiden name unknown15. Birthplace Mont. Co - Md16. Informant Sam E. OffuttAddress Rockville - R3D17. Burial Date thereof 7-26-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brook Grove MtLocation Rockville Md18. Funeral director Ray W. BarkerAddress Rockville Md19. July 26 19 47 Edna B. Lawler

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 - 1947 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 23 - 1947 to July 23 - 1947and that I last saw him/her live on July 23 - 47 19Immediate cause of death Hypertensive heartdiseaseDURATION 10 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations no

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Charles C. Tumbler M. D. orAddress Smiley Spring Md Date signed 7-24-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 5 1947

BUREAU 9 &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4604

## CERTIFICATE OF DEATH

06182

Reg. Diat. No. 213

## 1. PLACE OF DEATH:

County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80 yrs.Hospital, institution, or street address where death occurred:  
120 South Washington Street,How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 120 South Washington Street,  
(If rural, give LOCATION)2(a) If veteran, name war None

## 3. (a) FULL NAME

Mrs. Mary Gordon

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FemaleWhiteWidowed6. (b) Name of husband or wife Judge Edward C. Peter7. Birth date of deceased (mo., day, yr.) September 10, 18668. AGE: Years Months Days If less than one day  
80 80 10 10 - hrs. - min.9. Birthplace Rockville, Maryland  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name John Thomas Vinson13. Birthplace Darnestown, Maryland14. Maiden name Frances Racheal Prout15. Birthplace New York16. Informant Mrs. Albert Bouie (daughter)Address Rockville, Maryland17. Burial Date thereof July 22, 1947  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rockville Union CemeteryLocation Rockville, Maryland18. Funeral director Wm. Reuben HumphreyAddress Rockville, Maryland19. 7-21 47 EP Thompson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 19 47 at 7:20 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1929 19 47 to July 20 19 47and that I last saw her alive on July 19 19 47Immediate cause of death Carcinoma of sigmoid DURATION 1 year?Due to SymptomsDue to 2 yrs.Other conditions Diverterculosis of the large intestine

(Include pregnancy within 3 months of death)

Major findings of operations noneDate of op. —Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of —

Where did injury occur? (City or town) (Country) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. R. Thompson M.D. M. D. or otherAddress Rockville, Md. Date signed 7/22/47

RECEIVED  
JUL 22 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9-12

06183

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Damascus Md Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? five years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Damascus Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Col 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Elsworth Potts  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Oct 6, 1873  
 8. AGE: Years 73 Months 9 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Domestic11. Industry or business Home12. Name William Lyles13. Birthplace Maryland14. Maiden name Lydia Howard15. Birthplace Md16. Informant Thelma DundasAddress Damascus Md17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof July 10, 1947  
(month) (day) (year)Cemetery or crematorium FriendshipLocation near Clarksburg Md18. Funeral director Ray W. BarkerAddress Clarksburg Md19. July 10, 1947 Della W. Burdett  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1947 at 1:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1947 to 1947and that I last saw him alive on Sept 1947

Immediate cause of death \_\_\_\_\_

## DURATION

Coronary occlusion

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Frank J. Brochant M.D.23. SIGNATURE Depend exam M. D. or otherAddress Yantherburg Md Date signed 7-8-47

RECEIVED  
JUL 11 1947  
BUREAU V.B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

## CERTIFICATE OF DEATH

06184

Reg. Diat. No. 212

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Poolesville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery  
 City or town Poolesville  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Gertrude Virginia Price

## 3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 21 - 1876  
 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 71 Months 2 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Poolesville, Montg Co, Md  
 (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

12. Name Elias Price13. Birthplace Maryland14. Maiden name Mary A Carlisle15. Birthplace Maryland16. Informant Clara PriceAddress Poolesville, Md

17. Burial Date thereof 7/17/47  
 (Burial, cremation, or removal, Which?) (month) day (year)

Cemetery or crematory MonocacyLocation Beallsville, Md.18. Funeral director William B. WiltonAddress Barnesville, Md.

19. July 16 1947  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH July 15 - 1947 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 29 - 1943 to July 15 - 1947  
 and that I last saw him alive on July 15 - 1947

Immediate cause of death

Coronary-renal-vascular disease 5-yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

Byron D. White, M.D.  
 Address Poolesville, Md. Date signed 7/16/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## PROVIEW

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

## CERTIFICATE OF DEATH

06185

Reg. Dist. No. 216

## 1. PLACE OF DEATH

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 1/2 yrs.  
 Hospital, institution, or street address where death occurred:  
5019 Baltimore Ave  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Mt. G.  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5019 Baltimore Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex fe 5. Color or race W 6. (a) Single, married, widowed, or divorced divorced  
 6. (b) Name of husband or wife -

7. Birth date of deceased (mo., day, yr.) Apr. 12, 1890  
 6. (c) If alive, give age ..... years

8. AGE: Years 57 Months 3 Days 1 If less than one day ..... hrs. .... min.

9. Birthplace Roanoke, Va.  
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Anthony Albertoli

13. Birthplace

14. Maiden name Luceella Agnor

15. Birthplace Yoshen, Va.

16. Informant Dr. Albertoli

Address 5019 Balto. Ave. Bethesda Md

17. Shipment Date thereof 7/14/47  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Roanoke, Virginia

Location Virginia

18. Funeral director Wm Reuben Humphrey

Address 7557 Wis. Ave. Bethesda, Maryland

19. 7/14 19 47 gfm Eholes  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947 at 2:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. med. exam. case to 19  
 and that I last saw him alive on 19

Immediate cause of death

Coronary occlusion  
 Due to

Due to

Other conditions hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Broschard M.D. M. D. or other

Sept. med. exam. Address Gaithersburg Md Date signed 7-12-47

## DURATION

Instant death in bed

?

RECEIVED  
JUL 25 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 06186 213

## 1. PLACE OF DEATH

County Montgomery  
 City or town Rockville, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Montgomery County Montgomery  
 City or town Rockville, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Lillian C. Reddick

## 3. (b) Social Security Number

4. Sex Female5. Color or race Cobred6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Isaac Reddick

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) August 9, 1888  
 8. AGE: Years 59 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (Town, county, and state)

10. Usual occupation House Keeper

11. Industry or business \_\_\_\_\_

12. Name Turner Smith

13. Birthplace \_\_\_\_\_

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

16. Informant Isaac ReddickAddress 119 N. Washington St Rockville

17. Burial (Burial, cremation, or removal. Which?) July 15, 1947  
 Date thereof \_\_\_\_\_ (month) \_\_\_\_\_ (day) \_\_\_\_\_ (year)

Cemetery or crematorium Lincoln ParkLocation Rockville, Md.18. Funeral director Robert L. SnowdenAddress Rockville, Md.19. 7-15 47 EP Thompson

(Date rec'd by registrar) \_\_\_\_\_ Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 19 47 at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/8/47 19 47 to 7/12 19 47  
 and that I last saw him alive on 7/12 19 47

Immediate cause of death Chronic heart disease  
 DURATION 12 hours

Due to Hypertension 109 mm Hg

Due to \_\_\_\_\_

Other conditions Hypertension  
heart disease  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

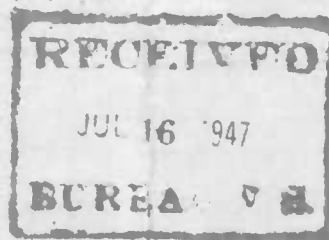
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Walter Wash 20.Address Rockville M. D. or other \_\_\_\_\_Date signed 7/15/47



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

06187

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

### 1. PLACE OF DEATH:

County Montgomery  
City or town Gaithersburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 20 yrs.  
Hospital, institution, or street address where death occurred:  
34 Walker Avenue,  
How long in hospital or institution? None

### 2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Gaithersburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 34 Walker Avenue,  
(If rural, give LOCATION)  
2.(a) If veteran, name war None

### 3. (a) FULL NAME

MATTIE ELLA REED

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Frederick A. Reed

7. Birth date of deceased (mo., day, yr.) May 31, 1883 8.(c) If alive, give age 64 years

8. AGE: Years 64 Months 64 Days 1 If less than one day 5 hrs. - min.

9. Birthplace Washington County, Maryland  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Charles W. Heffner

13. Birthplace Virginia

14. Maiden name Sarah McKinley

15. Birthplace Virginia

16. Informant Mr. Frederick A. Reed (husband)

Address Gaithersburg, Maryland

17. Burial Monocacy Cemetery Date thereof July 9, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Beallsville, Maryland

Location Beallsville, Maryland

18. Funeral director Wm. Reuben Humphrey

Address Bethesda 14, Maryland

19. July 8 1947 Abuda L. Cooke  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 6th, 1947 at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March - 4 - 1947 to July - 6 - 1947  
and that I last saw her alive on July 5 - 1947

Immediate cause of death my gangrene (anticoagulation) 6 days

Due to Cerebral Hemorrhage - 4 mo -

Due to anticoagulation 2 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William C. Miller, M.D. M. D. or other

Address Gaithersburg, Maryland Date signed 7/7/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 11 1947

BUREAU V A

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

06188

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 33 days

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, MarylandHow long in hospital or institution? 33 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 9008 Mohawk Lane  
(If rural, give LOCATION)2(a) If veteran, name war Sp.-Amer. & WW I

## 3. (a) FULL NAME

REID, Frank Ferreria

## 3. (b) Social Security Number

4. Sex  
male5. Color or race  
white6. (a) Single, married, widowed, or divorced  
married6. (b) Name of husband or wife Mrs. Louise M.D. Reid7. Birth date of deceased (mo., day, yr.) 15 August 1869  
6. (c) If alive, give age ..... years8. AGE: Years 77 Months 10 Days 21  
It less than one day  
..... hrs. .... min.9. Birthplace Europe  
(Town, county, and state)10. Usual occupation US. Navy Retired11. Industry or business US Navy12. Name unknown  
13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant Wife: Mrs. Louise M.D. Reid  
Address 9008 Mohawk Lane, Bethesda, Md.17. removal Date thereof 7-6-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar BluffLocation Annapolis, Maryland18. Funeral director JOHN M. TAYLOR CO. 992Address ANNAPOLIS, MARYLAND  
Mary Charlotte Smith19. 7-6-47 19 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6 July 19 47 at 11:45 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
6-3- 19 47, to 7-6- 19 47.  
and that I last saw him alive on 7-6- 19 47.Immediate cause of death Diabetes Mellitus

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury J.D. Wycoff Injured at work?23. SIGNATURE J.D. WYCOFF, LTJG MC USNR  
M. D. or otherAddress USNH Bethesda, Md. Date signed 7-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUL 21 1947

BUREAU 98

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

06189

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Easthursburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... since birth  
 Hospital, institution, or street address where death occurred:  
Diamond Ave.  
 How long in hospital or institution?...

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery  
 City or town... Easthursburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Diamond Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

David Matthew Refass

## 3. (b) Social Security Number

4. Sex... male 5. Color or race... White 6. (a) Single, married, widowed, or divorced... Single  
 6. (b) Name of husband or wife...  
 7. Birth date of deceased (mo., day, yr.)... July 22, 1947 6. (c) If alive, give age... years  
 8. AGE: Years... Months... Days... If less than one day...  
5 hrs. - min.

## MEDICAL CERTIFICATION

20. DATE OF DEATH... July 22 19... 47, at 7 A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 22 19... 47 to July 22 19... 47  
 and that I last saw him alive on... July 22 19... 47  
 Immediate cause of death...

## DURATION

Prematurity  
 Due to... (7 1/4 months)  
 Due to... (3 1/4 lbs)  
 Other conditions... none  
 (Include pregnancy within 8 months of death)

Major findings of operations... none Date of op. -  
 Autopsy results... none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of Injury Injured at work?

23. SIGNATURE... Wm. J. Lenthien, M.D. M. D. or other  
 Address... Rockville, Md. Date signed... 7/23/47

9. Birthplace... Easthursburg, Md.  
 (Town, county, and state)  
 10. Usual occupation... Infant  
 11. Industry or business...  
 12. Name... Howard Edgar Refass  
 13. Birthplace... Luckett, Va.  
 14. Maiden name... Ferna Margaret Heidman  
 15. Birthplace... Lincoln, Va.  
 16. Informant... Mrs. Howard E. Refass  
 Address... Easthursburg, Md.  
 17. Burial (Burial, cremation, or removal. Which?) Date thereof... July 23/47  
 (month) (day) (year)  
 Cemetery or crematory... Forest Oak  
 Location... Easthursburg, Md.  
 18. Funeral director... Ernest C. Guther  
 Address... Easthursburg, Md.  
 19. July 22 19... 47 Abraham G. Cooke  
 (Date recd by registrar) Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

## CERTIFICATE OF DEATH

06190

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County... MontgomeryCity or town... Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:

Washington SanitariumHow long in hospital or institution? 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... County...

City or town... D. C. Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1315 Shepherd St. N.W.

(If rural, give LOCATION)

2(a) If veteran, name war...

## 3. (a) FULL NAME

Marquerite Robertson

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Lewis Robertson7. Birth date of deceased (mo., day, yr.) Jan. 21 1891

6. (c) If alive, give age... years

8. AGE: Years Months Days If less than one day

56 5 10 hrs. min.9. Birthplace Paris, Va.

(Town, county, and state)

10. Usual occupation Clerk11. Industry or business genl. acct. Dept. Govt.12. Name William C. Fleming13. Birthplace Virginia14. Maiden name Mary B. Thompson15. Birthplace Virginia16. Informant Lena RobertsonAddress 1301 Longfellow St. N.W.17. Burial Date thereof July 5th 1947

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill CemeteryLocation Washington D.C.18. Funeral director J. Wm. Rees, Inc. CoAddress 300 - 4th St. N.E.19. July 2 1947

(Date recd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1947 at 9:50 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12th 1947 to July 1st 1947and that I last saw him alive on June 30th 1947Immediate cause of death Pulmonary embolismCerebral hemorrhage

DURATION

Due to Infarction of the brain infecting temple, frontal and parietal.Due to Femoral embolismArteriosclerosis of the brain

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results Pulmonary embolism and above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Fanny J. Hadley

M. D. or other

Address 1252 - 6th Street, S.W. Date signed 7/2/47

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JUL 7 1947  
BUREAU 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4704

## CERTIFICATE OF DEATH

Reg. Dist. No. 06191 276

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Chevy Chase  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Chevy Chase  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 8509 Linwood Place  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war No

## 3. (a) FULL NAME

MARGARET HILBUS SANGSTON

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Howard E. Sangston  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) February 13, 1880  
 8. AGE: Years 67 Months 5 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ft. Meyer, Virginia  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business At home  
 12. Name George Hilbus  
 13. Birthplace Virginia  
 14. Maiden name Margaret ?  
 15. Birthplace Virginia

16. Informant H. Earl Sangston  
 Address 8509 Linwood Pl. Chevy Chase  
 17. Burial Date thereof July 17, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Glenwood Cem.  
 Location Washington, D. C.  
 18. Funeral director S. H. Hines Co.  
 Address 2901 14th St., N.W. D.C.  
 19. 7/14 19 47 Mr E. Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 19 47 at 8 M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 19 47 to July 14 19 47  
 and that I last saw him/her alive on July 14 19 47  
 Immediate cause of death Carcinoma, lung, etc  
 DURATION 2 yrs.  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions None  
 (Include pregnancy within 3 months of death)  
 Major findings of operations None  
 Date of op. \_\_\_\_\_  
 Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Philip H. Varner, M.D.  
 M. D. or other \_\_\_\_\_  
 Address 1202 Conn. Ave. Date signed 7-14-47

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JUL 25 1947  
SERIAL 52

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Under correct age is especially important. Physicians: please write the causes of death clearly and legibly. ✓

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06192

Reg. Dist. No. 223

<b>1. PLACE OF DEATH:</b> County <u>Montgomery</u> City or town <u>Takoma Park</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>101 Holly Ave.</u> How long in hospital or institution?			<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>MD.</u> County <u>Montgomery</u> City or town <u>Takoma Park</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>101 Holly Ave.</u> (If rural, give LOCATION) 2.(a) If veteran, name war		
<b>3. (a) FULL NAME</b> <u>ANNETTA M. SHANAFELT.</u>			<b>3. (b) Social Security Number</b> _____		
<b>4. Sex</b> <u>F</u> <b>5. Color or race</b> <u>W</u> <b>6. (a) Single, married, widowed, or divorced</b> <u>WIDOWED</u>			<b>MEDICAL CERTIFICATION</b>		
<b>6. (b) Name of husband or wife</b> _____			<b>20. DATE OF DEATH</b> <u>30 July</u> 19 <u>47</u> at <u>1:25 P.</u> M		
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>MARCH 13, 1862.</u>			<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Nov. 1</u> 19 <u>46</u> to <u>30 July</u> 19 <u>47</u> and that I last saw h. <u>he</u> alive on <u>30 July</u> 19 <u>47</u>		
<b>8. AGE:</b> Years <u>85</u> Months <u>4</u> Days <u>17</u> If less than one day _____ hrs. _____ min.			<b>Immediate cause of death</b> <u>Acute cardiac failure</u>		
<b>9. Birthplace</b> <u>FREEPORT, PENNA.</u> (Town, county, and state)			<b>DURATION</b> <u>24 hrs.</u>		
<b>10. Usual occupation</b> <u>AT HOME.</u>			<b>Due to</b> <u>arteriosclerosis, senile, senescent</u> <u>8-10 years.</u>		
<b>11. Industry or business</b>			<b>Due to</b> _____		
<b>12. Name</b> <u>Unknown</u>			<b>Other conditions</b> <u>mitral insufficiency</u>		
<b>13. Birthplace</b> <u>PA.</u>			(Include pregnancy within 3 months of death)		
<b>14. Maiden name</b> <u>Unknown</u>			<b>Major findings of operations</b> _____		
<b>15. Birthplace</b> <u>PA.</u>			Date of op. _____		
<b>16. Informant</b> <u>HARRY GARVER.</u> Address <u>101 HOLLY AVE, TAKOMA PARK, MD.</u>			<b>Autopsy results</b> _____ <b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.		
<b>17. Burial</b> (Burial, cremation, or removal. Which?) Date thereof <u>AUG 3, 1947.</u> (month) (day) (year) Cemetery or crematory <u>BELMONT CEMETERY</u> Location <u>BELMONT, (WRIGHT COUNTY) IOWA.</u>			<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) (County) (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____		
<b>18. Funeral director</b> <u>J. ARTHUR WALTERS</u> Address <u>254 CARROLL ST. N.W. TAKOMA PARK, D.C.</u>			<b>23. SIGNATURE</b> <u>HOB Green M.D.</u> Address <u>112 Willow Ave Takoma Park Md.</u> M. D. or other _____ Date signed <u>30 July 47</u>		
<b>19. Date rec'd by registrar</b> <u>July 31 47</u> Registrar _____					

RECEIVED  
AUG 1 1947  
BUREAU OF

C40  
COPY SENT TO ~~SEN~~ REGISTRAR No. \_\_\_\_\_ DATE 8-1-47

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

06193

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

## 1. PLACE OF DEATH:

County MONTGOMERY  
 City or town HUNTINGHILL  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 38 yrs.  
 Hospital, institution, or street address where death occurred:  
OWN HOME  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County MONTGOMERY  
 City or town HUNTING HILL  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.T.D.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war NO

## 3. (a) FULL NAME

LUCY J. SIMMS

## 3. (b) Social Security Number

NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED  
 8. (b) Name of husband or wife M.C. SIMMS 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) NOVEMBER 20, 1872  
 8. AGE: Years 74 Months 7 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace CULPEPPER, VIRGINIA  
 (Town, county, and state)  
 10. Usual occupation HOUSE WIFE  
 11. Industry or business OWN HOME

FATHER 12. Name JAMES R. SOUTTER  
 13. Birthplace CULPEPPER, VIRGINIA  
 MOTHER 14. Maiden name ELIZABETH HITT  
 15. Birthplace CULPEPPER, VIRGINIA  
 16. Informant HARRY A. SIMMS  
 Address ROCKVILLE, MARYLAND  
 17. BURIAL Date thereof 7-13-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory ROCKVILLE UNION CEMETERY  
 Location ROCKVILLE, MARYLAND  
 18. Funeral director W. R. R. Thompson  
 Address ROCKVILLE, MARYLAND

19. July 12 1947 Mrs. E. P. Thompson  
 (Date rec'd by registrar) Registrar Chas. L. E. Boudette

## MEDICAL CERTIFICATION

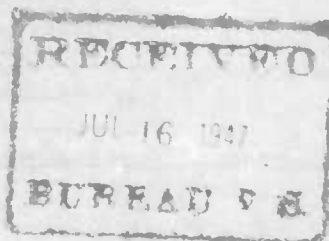
20. DATE OF DEATH July 11 1947, at 4:15 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1930 to July 11 1947  
 and that I last saw him alive on July 10 1947  
 Immediate cause of death Coronary occlusion  
 Due to arteriosclerosis  
 Due to \_\_\_\_\_  
 Other conditions Duration coronary occlusion  
 (Include pregnancy within 3 months of death)  
 Major findings of operations none Date of op. \_\_\_\_\_  
 Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE W. R. R. Thompson M.D.  
 Address Rockville, Md. Date signed 7/14/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92a

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

06194

212

**1. PLACE OF DEATH:**

County... Montgomery

City or town... Rockville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Years

Hospital, institution, or street address where death occurred:  
.....  
.....

How long in hospital or institution? .....

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Rockville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 503 W. Montgomery Ave.  
(If rural, give LOCATION)  
World War I

2.(a) If veteran, name war .....

**3. (a) FULL NAME** HENRY Coy SIMS

**3. (b) Social Security Number** .....

**4. Sex** Male **5. Color or race** White **6. (a) Single married, widowed, or divorced** Married

**6. (b) Name of husband or wife** Olivia Kenley Sims

**7. Birth date of deceased (mo., day, yr.)** September 5, 1891

**6. (c) If alive, give age** 49 years

**8. AGE:** Years Months Days If less than one day  
55 10 11 ..... hrs. .... min.

**9. Birthplace** Brevard- North Car.  
(Town, county, and state)

**10. Usual occupation** Builder

**11. Industry or business** Builder

**FATHER**

**12. Name** Unknown

**13. Birthplace** Unknown

**MOTHER**

**14. Maiden name** Sarah Sims

**15. Birthplace** North Car.

**16. Informant** Olivia Kenley Sims  
Address Rockville, Maryland

**17. Burial** Date thereof 7/18/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Arlington National Cem.  
Location Arlington Va.

**18. Funeral director** W. Reuben Humphreys  
Address 7557 Wis. Ave. Bethesda, Md.

**19.** July 17, 1947 SP Simpson  
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** July 16, 1947 at 4:50 PM

**21. I CERTIFY** that death occurred on the date above stated; that I attended deceased from May, 1947 to July 16, 1947  
and that I last saw him alive on July 16, 1947

**Immediate cause of death** Coronary thrombosis

**DURATION** 8 years

**Due to** coronary sclerosis

**Other conditions** arteriosclerosis

(Include pregnancy within 3 months of death)

**Major findings of operations** .....

**Autopsy results** As Above Coronary Sclerosis

**PHYSICIAN:** Please underline the cause to which death should be charged statistically.

**22. VIOLENCE:** If death was due to external causes, fill in the following:

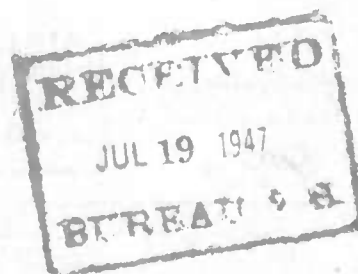
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

**23. SIGNATURE** Willie Willard M. D. or other  
Address Rockville, MD Date signed 7/16/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 96

## CERTIFICATE OF DEATH

06195

Reg. Dist. No. 316

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since 7-17-47  
 Hospital, institution, or street address where death occurred Suburban Hosp  
8600 Old Georgetown Rd Bethesda Md.  
 How long in hospital or institution? Since 7-17-47

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Gaithersburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.R. #3  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war Unknown

## 3. (a) FULL NAME

Mr Edulard Snyder

## 3. (b) Social Security Number

UNKNOWN

4. Sex M 5. Color or race W. 6.(a) Single, married, widowed, or divorced MARRIED  
 6.(b) Name of husband or wife Essie Mae Snyder  
 6.(c) If alive, give age 35 years  
 7. Birth date of deceased (mo., day, yr.) December 30, 1883  
 8. AGE: Years 63 Months 6 Days 19 hrs. min.  
 9. Birthplace MOOREFIELD, Virginia  
 (Town, county, and state)  
 10. Usual occupation Saw Mill Operator  
 11. Industry or business

FATHER 12. Name James Buchanan Snyder  
 13. Birthplace West Virginia  
 MOTHER 14. Maiden name Susan Rexroad  
 15. Birthplace MOOREFIELD, West Virginia

18. Informant Mrs. ESSIE MAE SNYDER  
 Address TRAVILAH - Md.  
 17. BURIAL Date thereof July 22, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery  
 Location FREDERICK, Md.  
 18. Funeral director M. R. F. Johnson & Son  
 Address FREDERICK - Md.  
 19. 7/21/47 Wm E Jobs  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 19 1947 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18, 1947, to July 19, 1947  
 and that I last saw him alive on July 19, 1947

Immediate cause of death Rupture of Aortic aneurysm  
Was not due to appendicitis  
 Due to cause unknown

Other conditions Renal peritoneal hemorrhage (massive)  
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results Aortic aneurysm  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE W.B. Ford M.D.  
 Address Suburban Hospital Bethesda Md.  
 Date signed July 19, 1947

RECEIVED  
JUL 25 1947  
BUREAU F R

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

## CERTIFICATE OF DEATH

06196

Reg. Dist. No. 214

### 1. PLACE OF DEATH:

County Montgomery County  
City or town Silver Springs, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 10,000 Georgia  
Maple Lane Sanatorium Ave. Sil. Sp. Md.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince George  
City or town College Park, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4704-Drexel Road  
(If rural, give LOCATION)

2(a) If veteran, name war

### 3. (a) FULL NAME

Jessie Katie Starr

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Samuel Homer Starr

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1872

8. AGE: Years 75 Months 3 Days 3 If less than one day hrs. min.

9. Birthplace Cohocton, Stuten Co. N.Y.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name A.R. Cady 13. Birthplace Unk., New York State

MOTHER 14. Maiden name Frances Watson 15. Birthplace Unk., New York State

16. Informant Phillip D. Starr  
Address 4704-Drexel Rd. College Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/2/47  
(month) (day) (year)

Cemetery or crematory Glenwood Cemetery

Location Binghamton, N.Y.

18. Funeral director The S.V. Hines Co

Address 2901 14th St. N.W.

19. Date rec'd by registrar July 1 1947 Registrar J. J. Schaeffer

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1947 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 16 1947 to July 1 1947  
and that I last saw him alive on July 1 1947

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to Hypertension

Due to Arteriosclerosis

Other conditions General debility  
Senility  
(Include pregnancy within 8 months of death)

Major findings of operations No operations

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

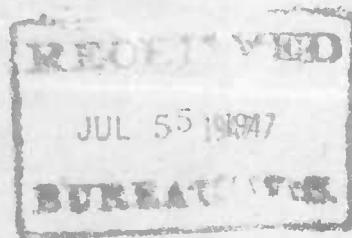
23. SIGNATURE Henry R. Lowder M.D. M. D. or other

Address 1603 19th St. N.W. Date signed 7-1-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46 *ex*

## CERTIFICATE OF DEATH

06197  
Reg. Dist. No. 223

### 1. PLACE OF DEATH

County *Montgomery*  
City or town *Farmington Park*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

*224 - Holly Ave - Farmington Park*

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Montgomery*

City or town *Farmington Park*  
(If outside city or town limits, write RURAL and give nearest town)

Street No. *224 - Holly Ave*  
(If rural, give LOCATION)

2.(a) If veteran, name war.

### 3. (a) FULL NAME

*Lottie Denny Daughton*

### 3. (b) Social Security Number

4. Sex *F* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife.

*Sept. 21 - 1871* 6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) *Sept 21, 1871*

8. AGE: Years *76* Months Days If less than one day hrs. min.

9. Birthplace *Wisconsin*  
(Town, county, and state)

10. Usual occupation *House Wife*

11. Industry or business

12. Name *Isaac Denny*

13. Birthplace *?*

14. Maiden name *Elizabeth Wade*

15. Birthplace *London - England*

16. Informant *Mrs. Charlotte Denny*

Address *8349 - Cobleside Rd. S.S.*

17. *Burial* Date thereof *July 22, 1947*  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Large Hill - Memorial*

Location *Biggs Road - Farmington*

18. Funeral director *W. H. H. H. H.*

Address *254 Cottage St. Farmington*

19. *July 21* 19 *47*  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *7/20* 19 *47*, at *5:00* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*2/11* 19 *47* to *7/20* 19 *47*  
and that I last saw him alive on *7/10* 19 *47*

Immediate cause of death *Intestinal Obstruction* DURATION *7 days*

Due to *Carcinoma of Sigmoid with metastases*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations *As above - Cecalomyoma* Date of op. *6/1/47*

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; *L*

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *[Signature]* M. D. or other

Address *Farmington* Date signed *7/20/47*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED  
JUL 22 1947  
BUREAU V.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

## CERTIFICATE OF DEATH

06198

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 yr. 6 mos. 4 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 1 yr. 6 mos. 4 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1717 H St., N.W.  
(If rural, give LOCATION)  
2. (a) If veteran, name war Sp. Am.

### 3. (a) FULL NAME

SUMMERLIN, George Thomas

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced widowed  
6. (b) Name of husband or wife Mrs. Brair Spencer  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) November 11, 1872  
8. AGE: Years 74 Months 7 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace La.  
(Town, county, and state)

10. Usual occupation unemployed

11. Industry or business \_\_\_\_\_

12. Name Summerlin, John S. dec.

13. Birthplace Ala.

14. Maiden name Davis, Molly, dec.

15. Birthplace La.

16. Informant granddaughter: Mrs. Hugh Stevens

Address 2300 Woodley Road, N. W., Wash., D.C.

17. burial Date thereof 7-3-47  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director Joseph Gawler Sons (USA)

Address 1756 Pennsylvania Ave., N.W., Wash., D.C.

19. 7-1 19 47 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 1 July 19 47 at 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Dec. 19 45 to 1 July 19 47

and that I last saw him alive on 1 July 19 47

Immediate cause of death \_\_\_\_\_

Cerebral Hemorrhage

Pyelonephritis

Due to Arteriosclerosis, General

Prostatic Hypertrophy

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature J. B. Shulder

23. SIGNATURE J. B. SHULDER, CDR. MC USN  
M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 7-1-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

718147

RECEIVED

JUL 14 1947

BUREAU OF A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 470 X

## CERTIFICATE OF DEATH

06199  
Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 mo. 24 days  
Hospital, institution, or street address where death occurred:  
U. S. Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 1 mo. 24 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D. C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1134 Chaplin Street, Southeast  
(If rural, give LOCATION)  
2(a) If veteran, name war WW I

## 3. (a) FULL NAME

VERGA, Henry Vincent

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Cecilia Verga  
7. Birth date of deceased (mo., day, yr.) 11 April 1891  
6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 56 Months 3 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Italy  
(Town, county, and state)  
10. Usual occupation unknown  
11. Industry or business unknown  
12. Name Alfonso Verga  
13. Birthplace Italy  
14. Maiden name unknown  
15. Birthplace unknown

16. Informant Wife: Mrs. Cecilia Verga  
Address 1134 Chaplin St., SE, Wash., D. C.  
17. Burial Date thereof 7 28 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Location Arlington, Virginia  
18. Funeral director W. W. Chambers Co. Inc.  
Address 517 11th Street, S. E., Wash., D. C.

19. 7-24-47 19 \_\_\_\_\_  
(Date rec'd by registrar) Registrar W. C. Smith

## MEDICAL CERTIFICATION

20. DATE OF DEATH 24 July 19 47 at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-31 19 47, to 7-24 19 47  
and that I last saw him alive on 7-24 19 47

Immediate cause of death Respiratory Failure  
Due to Bronchogenic carcinoma of right lung DURATION 3 mos. +  
Due to post-operatively  
Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)  
Major findings of operations Bronchogenic carcinoma, R.L. Bronchi Date of op. 12 May 47  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John D. Perkins M.D. M. D. or other M.D.  
Address B. N. NMC Date signed 24 July 47



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

06200

## CERTIFICATE OF DEATH

Reg. Dist. No. 514

1. PLACE OF DEATH: *Mountgomery*  
 County 5 Cresthaven Drive, Hillendale  
 City or town Silver Spring, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Md. County  
 City or town Silver Spring, Mo.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5 Cresthaven Drive, Hillendale  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

### 3.(a) FULL NAME

Barbara B. Vrabek

### 3.(b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Stephen

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1862

8. AGE: Years 84 Months Days If less than one day hrs. min.

9. Birthplace Czechoslovakia  
 (Town, county, and state)

10. Usual occupation housewife

### 11. Industry or business

12. Name Martin Benier

13. Birthplace Czechoslovakia

14. Maiden name

15. Birthplace

18. Informant Miss Barbara T. Vrabek

Address 2011 R. Street N.W. Wash.D.C.

17. Cremation Date thereof 7/3/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Rude's Church

Location The P. H. Niles Co

18. Funeral director The P. H. Niles Co

Address 2901-14 st NW

19. July 2 19 47 Josephine McShoeffer  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 19 47, at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 19 47, to July 2 19 47

and that I last saw him alive on July 1 19 47

Immediate cause of death Myocardial thrombosis DURATION 18 hr

Hypertensive and

arteriosclerotic heart

disease many years

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Doughton M. D. or other

Address 2011 R St NW Date signed 7/2/47

Washington D.C.

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 5 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of sex is shown on MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

FILM No. G 110 JUL 23 1947 CERTIFICATE OF DEATH

06201

Reg. Dist. No. 223-

1. PLACE OF DEATH:  
County Montgomery  
City or town Takoma Park, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Dist. of Col. County  
City or town Washington, D.C.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5402 Worthington Drive, Westgate, Md.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME  
MRS. CHARLOTTE R. WADSWORTH

3. (b) Social Security Number

4. Sex Male female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Mr. Wadsworth  
7. Birth date of deceased (mo., day, yr.) December 29th, 1867  
8. AGE: Years 79 Months Days If less than one day  
hrs. min.

9. Birthplace Buffalo, New York  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business

FATHER 12. Name John Rathe  
13. Birthplace  
MOTHER 14. Maiden name Charlotte Rathe  
15. Birthplace Canada

16. Informant Mr. Robert L. Wadsworth  
Address 5402 Worthington Drive, Westgate, Md.

17. Removal Date thereof July 16, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Glenwood Cemetery  
Location Washington, D.C.

18. Funeral director Martin W. Thompson  
Address 1300 N. Street, N.W., Wash., D.C.

19. 7/16/47 19 47  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 16th, 19 47 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 19 47, to July 16 19 47  
and that I last saw him alive on July 9 19 47

Immediate cause of death  
Cerebral aneurysm  
Myocardial infarction  
hypertension chronic  
DUE TO  
DUE TO  
Other conditions  
DURATION  
2 wks  
acc. H. H. H.

(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)

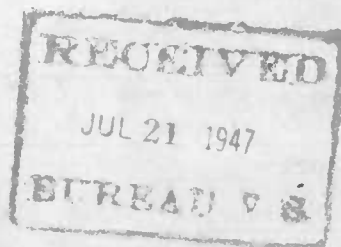
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Richard A. [Signature] M. D. or other  
Address 2100 North Capital St Date signed July 16, 1947

Dr. MacDonald (Cormier) Notified

6/17/47

Refused.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a x

## CERTIFICATE OF DEATH

06202  
Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 months, 24 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 3 months, 24 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Indiana County Hammond  
City or town Hammond  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1520 Cedar Avenue  
(If rural, give LOCATION)  
2. (a) If veteran, name war none Navy

### 3. (a) FULL NAME

WELLS, Orville Martin

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 14 March 1928 6. (c) If alive, give age 19 years

8. AGE: Years 19 Months 3 Days 25 It less than one day hrs. min.

9. Birthplace Ind.  
(Town, county, and state)

10. Usual occupation Navy

11. Industry or business

12. Name Orville Wells

13. Birthplace Ind.

14. Maiden name Rose Rybnsky

15. Birthplace Ind.

16. Informant mother: Mrs. Rose Wells

Address 1520 Cedar Avenue, Hammond, Ind.

17. burial Date thereof 7-11-47  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Elmwood Cemetery

Location Hammond, Ind.

18. Funeral director W. W. CHAMBERS

Address 1400 Chapin St., N.W., Wash., D.C.

19. 7-10 19 47 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 9 July 19 47 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 19 47 to July 9 19 47

and that I last saw h. in alive on 9 July 19 47

Immediate cause of death Leukemia, Chronic, Myelogenous

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury J.D. Wycoff Injured at work?

23. SIGNATURE J. D. WYCOFF, Lt. (jg) (MC) USNR

M. D. or other

Address USNHospital, Bethesda, Md. Date signed 7-10-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M  
7/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

06203

Reg. Dist. No. 211

### 1. PLACE OF DEATH:

County Montgomery  
City or town near Damascus  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Samuel Aaron Welsh

### 3. (b) Social Security Number

4. Sex M 5. Color or race Colored 6. (a) Single, married, widowed, divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1880

8. AGE: Years 66 Months 9 Days 8 If less than one day hrs. min.

9. Birthplace Montgomery  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farmer

12. Name Ben Welsh

13. Birthplace Montgomery

14. Maiden name Ellen Kelly

15. Birthplace Montgomery

18. Informant Edith Jackson

Address Monrovia

17. (Burial, cremation, or removal, Which?) Burial Date thereof July 19, 1947  
(month) (day) (year)

Cemetery or crematory Funeral Home

Location near Damascus

18. Funeral director H. M. Linder

Address mt. Airy

19. July 18 19 47 Della W. Burdett  
(Date rec'd by registrar) Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery

City or town near Damascus  
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1947 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 22, 1943 to July 17, 1947  
and that I last saw him alive on July 17, 1947

Immediate cause of death Anterior wall myocardial infarction  
vascular disease DURATION 15 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James P. Kern M.D.

M. D. or other

Address Damascus, Md. Date signed 7/18/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 21 1947  
BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4684

## CERTIFICATE OF DEATH

Reg. Dist. No. 062143

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 days  
 Hospital, institution, or street address where death occurred:  
Washington San Hosp.  
 How long in hospital or institution? 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County D.C.  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7511 12th St. N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ☒

## 3. (a) FULL NAME

Mr. Frank P. Wollner

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Margaret Wollner  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) April 24, 1898  
 8. AGE: Years 69 Months 2 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Port Jervis N.Y.  
 (Town, county, and state)  
 10. Usual occupation Meat Cutter  
 11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name Earnest Wollner  
 13. Birthplace Port Jervis N.Y.  
 14. Maiden name Ida Turk  
 15. Birthplace Germany

16. Informant Self on entrance to Hosp.  
 Address 7511 12th St. N.W. City  
 17. Burial Date thereof July-5-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rock Creek Cemetery-D.C.  
 Location Washington-D.C.

18. Funeral director Seal Funeral Home  
 Address 4812 Ga. Ave. N.W.

19. July 2 19 47  
 (Date rec'd by registrar) Registrar [Signature]

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 19 47 at 11:20 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 19 47 to July 1 19 47  
 and that I last saw him alive on July 1 19 47  
 Immediate cause of death \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings of operations Ch. 4th stomach & mass involving liver gall bladder. Pancreas. Date of op. 6/30/47  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Howard I. House M.D. or other MD  
28 Carroll Ave Takoma Park  
 Address \_\_\_\_\_ Date signed 7/2/47

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JUL 7 1947  
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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

06205

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda 14  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 yrs.  
 Hospital, institution, or street address where death occurred:  
#1 Verne Street,  
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Bethesda 14  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. #1 Verne Street,  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

ROBERT EDWARD LEE YELLOTT

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Lillian Wright Yellott  
 (deceased) 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) August 2, 1868  
 8. AGE: Years 78 Months 78 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation Broker11. Industry or business Real Estate12. Name Coleman Yellott13. Birthplace Bel Air, Maryland14. Maiden name Mary Virginia Rust15. Birthplace Leesburg, Virginia16. Informant Mrs. Richard E. Wiley (daughter)Address Alexandria, Virginia17. Burial Date thereof July 7, 1947  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Washington, D. C.18. Funeral director Wm. Randolph RumpffAddress Bethesda 14, Maryland19. 7/7 19 47 Thos E. Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 5th 1947 at 29 M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 28 1947 to July 5 1947and that I last saw him alive on July 5 1947Immediate cause of death Coronary occlusion DURATION 7 daysDue to Ch: arteriosclerosis ?Due to Diabetes Mellitus ?

Other conditions \_\_\_\_\_ ?

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE E. G. Bauerfeld M.D. M. D. or otherAddress Bethesda 14, Maryland Date signed 7/6/47

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUL 12 1947  
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06206

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... TAKOMA PARK  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 minutes  
 Hospital, institution, or street address where death occurred:  
WASHINGTON SANITARIUM & HOSPITAL  
 How long in hospital or institution? 30 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... MARYLAND County... MONTGOMERY  
 City or town... SILVER SPRING  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2905 STANTON AVE  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... NO

## 3. (a) FULL NAME

FRANCES ANN ZUBRECKY

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

SINGLE

## 6. (b) Name of husband or wife

6. (c) If alive, give age... years

## 7. Birth date of

deceased (mo., day, yr.) JULY 25, 1947

## 8. AGE:

Years

Months

Days

If less than one day

hrs. 30 min.

## 9. Birthplace

TAKOMA PARK  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

MR. STEPHEN JOHN ZUBRECKY

## 13. Birthplace

Pittsburg, Pa.

## 14. Maiden name

Mrs. Frances A. Zubrecky  
TOMES

## 15. Birthplace

Ame, Oregon

## 16. Informant

WASHINGTON SANITARIUM & HOSPITAL

## Address

TAKOMA PARK 12, MARYLAND

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

JULY 29, 1947  
(month) (day) (year)

## Cemetery or crematory

CEAR HILL

## Location

SUITLAND, PRINCE GEORGES CO. MD.

## 18. Funeral director

Edwards & Humphrey

## Address

SILVER SPRING, MD.

## 19.

July 28, 1947  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 7-25 19 47, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-25 19 47, to 7-25 19 47and that I last saw her alive on 7-25-47 19

Immediate cause of death

Asphyxiation  
of newborn

Due to

other causes  
unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address... 9601 GA. AVE. SILVER SPRING Date signed 7/28/47

RECEIVED  
JUL 30 1947  
BUREAU P.R.